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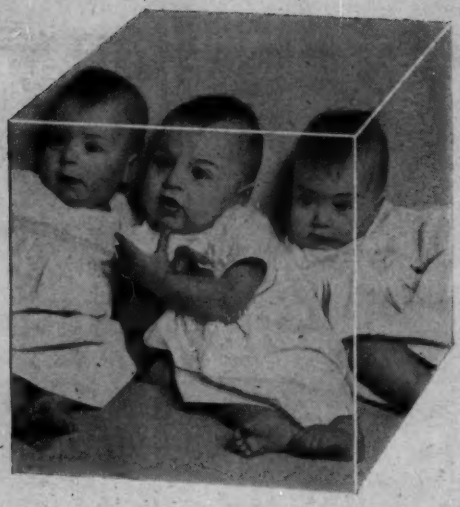

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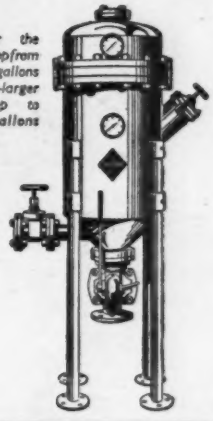

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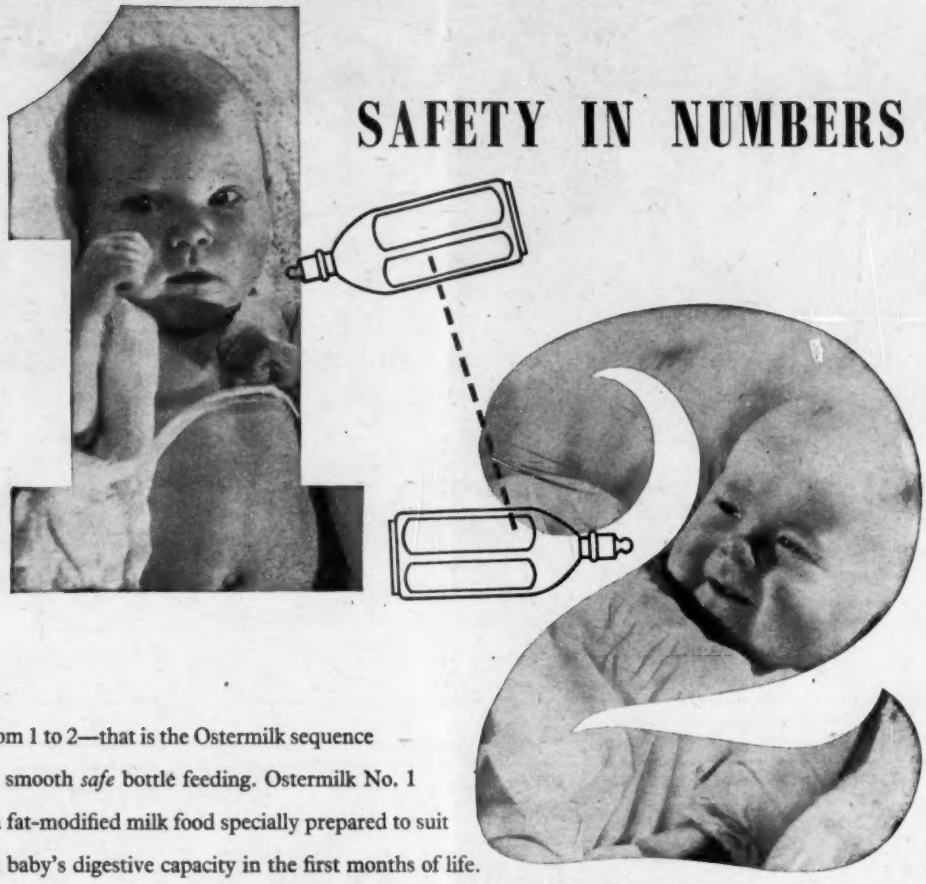

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The reports of the proceedings of the Society's Council and its committees are to take a new selective form, as published in* PUBLIC HEALTH, *beginning with the present issue. It was felt that the reports hitherto printed in the journal, being in fact the full minutes of meetings, were so long and detailed that matters of particular interest to all members of the Society were lost in the jungle of routine and administrative items. We have been asked therefore to publish in the opening pages of this issue, which would normally be occupied by editorial comments, the following report of the main matters which came before the Council and the General Purposes Committee at their last meetings.—Editor, PUBLIC HEALTH.

COUNCIL MEETING

The last meeting of the Council of the Society for the Session 1953–54 was held on Friday, September 17th, when 36 members were present.

Chairman.—The first important item to be dealt with was the election of a Chairman to succeed Dr. J. M. Gibson who, although remaining a member of Council, was taking the chair for the last time. Dr. H. K. Cowan had been elected to fill this vacancy at a previous meeting, but had subsequently been appointed to the position of Chief Medical Officer to the Department of Health for Scotland and was therefore unable to accept the position. On the proposition of Dr. J. S. G. Burnett it was unanimously agreed that Dr. C. Metcalfe Brown (Medical Officer of Health, Manchester C.B.) be appointed chairman in his place.

The retiring Chairman congratulated Dr. Metcalfe Brown on his election and also congratulated Dr. Cowan on his well-deserved appointment. In his reply Dr. Cowan paid tribute to the assistance he had had during his period of service on the Council and as Chairman of the General Purposes Committee from the office staff.

By virtue of his appointment Dr. C. Metcalfe Brown will become *ex officio* a member of the Central Health Services Council, and consequently of the Standing Medical Advisory Committee. Dr. Kenneth Cowan had been a member of the Standing Medical Advisory Committee, and it was agreed to nominate Dr. H. C. Maurice Williams to take his place. Dr. H. C. Maurice Williams was also elected a Vice-President of the Society in the place of Dr. Metcalfe Brown.

Functions of the Medical Officer of Health.—The Council received the draft of a comprehensive document setting out the Society's considered views on the proper functions of a Medical Officer of Health. In receiving this document the Council expressed its grateful thanks to the Yorkshire Branch and to Professor C. Fraser Brockington who had been responsible for the preparation of a document on which the Special Committee's recommendations were based. The document was accepted as the Society's policy for separate publication in the near future.

Co-option of Members on the Council.—Under the Articles of Association, the Meeting dealt with the co-option of seven members to serve on the Council for the forthcoming session and it was agreed that Drs. James Fenton, E. K. Macdonald and Hugh Paul be co-opted under Article 19 (d) and Professor C. Fraser Brockington, Sir John Charles, Sir Allen Daley and Professor G. S. Wilson be co-opted under Article 19(f).

Dr. G. F. Buchan.—The Council noted with regret that Dr. George Buchan, at his own request, was retiring from membership of Council after a period of 42 years' continuous service. Dr. J. M. Gibson, on behalf of the Council, said how much Dr. Buchan's wise counsel would be missed and referred in glowing terms to the wise and helpful influence Dr. Buchan had exercised over this very long period. Dr. Buchan has received every honour that the Society can bestow, having been an Honorary Fellow for a number of years.

Whitley Committee.—Dr. A. V. Kelynack, Assistant Secretary of the B.M.A., reported briefly on certain matters which had been dealt with by Whitley Committee "C," in connection with salaries and conditions of service. The Council then adopted the recommendations of the special sub-committee which had drawn up suggestions for the consideration of the Staff Side of Committee "C," for an immediate approach to be made to the Management Side for an all-round improvement in the existing salary scales. A document has been forwarded to Dr. Kelynack, as Secretary of the Staff Side. The special sub-committee will continue its discussions and will draw up a document for submission to the Hamilton Committee of the B.M.A., which was set up at the Annual Representative Meeting of that body in Glasgow this year to consider general principles

of relationship between the various salary scales in the medical profession.

Duties of Nurses.—It was reported that the Ministry of Health had agreed to ask representatives of the Society to take part in discussions about the duties proper to a nurse. This important question had been discussed at a meeting of the General Purposes Committee when Dr. Robert Forbes had attended to take part in the discussion. The Chairman of the General Purposes Committee reported to Council that the Royal College of Nursing was drawing up a document on the legal position of the nurse undertaking procedures outside her professional scope, and that the Society would have an opportunity of commenting on this document before it was finally approved.

The question was raised as to the advice to be given to Medical Officers of Health regarding their legal position and responsibility for procedures undertaken by nurses in the employ of the local authority. The Society is in general agreement with the Public Health Committee of the B.M.A. on this matter, and it was considered that, should it be thought necessary for nurses to be so employed, the Medical Officer of Health concerned should seek the approval of the appropriate Committee of the Local Authority, so that his legal position should be adequately safeguarded.

Meat Inspection.—Dr. Cowan reported that the General Purposes Committee had agreed to inform the Ministry of Food that the Society would welcome any proposal to make meat inspection compulsory at all slaughter-houses. but it was felt that no charge should be levied by Local Authorities for this valuable service to the community. The General Purposes Committee had also considered the publication by the British Veterinary Association of a pamphlet entitled "Report on Meat Inspection Control in Western Europe," copies of which had circulated to all Members of Parliament and to the Ministries of Health, Food and Agriculture and Fisheries. Besides being a factual account of the visit of two Members of Parliament and two veterinary surgeons to slaughter-houses in several countries in Western Europe, it contained a statement that meat inspection services in England and Wales should be brought under veterinary control. The British Veterinary Association had stated subsequently that this pamphlet was not the official policy of that organisation. It was agreed to co-operate with the Sanitary Inspectors Association and the British Medical Association in making arrangements for further joint meetings to discuss the position.

Annual Dinner of the Society.—The Council received with pleasure the statement that the Minister of Housing and Local Government had accepted the invitation of the Society to be the principal guest at the Annual Dinner which is to be held at the Connaught Rooms, on Thursday, November 25th, 1954.

Programme of Meetings for the Session 1954-55.—The Council approved the recommendation of the General Purposes Committee that the following programme of meetings be arranged during the forthcoming session :—

1954

Thursday, November 25th, 6.45 for 7.15 p.m., Annual Dinner (Connaught Rooms).

Friday, November 26th, 10 a.m., Council Meeting.

1955

Friday, January 14th, 10 a.m., General Purposes Committee ; 12.45 p.m., Annual General Meeting.

Friday, March 4th, 10 a.m., Council Meeting.

Friday, April 15th, 10 a.m., General Purposes Committee.

Friday, June 17th, Provincial Meeting of Council and Ordinary Meeting of the Society (Birmingham).

Friday, July 15th, 10 a.m., General Purposes Committee.

Thursday, September 22nd, 5.30 p.m., Ordinary Meeting. Installation of President.

Friday, September 23rd, 10 a.m., Council Meeting.

Other Matters from G.P.C.—The following other matters were also reported as having been dealt with by the General Purposes Committee :—

Comments on the Revised Syllabus of Training for the Certificate of Fever Nursing, appointment of representatives to submit oral evidence to the Working Party on the Training of District Nurses, arrangements for the preparation of a Memorandum for submission to the Committee on Air Pollution and the approval of a Memorandum for issue by the Ministry of Health for the Guidance of Medical Officers of Health on the Nursing of Infective Tuberculous Patients in Their Own Homes.

Diploma in Public Health.—The Council received an invitation from the General Medical Council for advice to be given as to any suggested alterations to the regulations governing examinations for the Diploma in Public Health, and also an invitation from the Ministry of Health for representatives of the Society to discuss such suggestions with officers of the Ministry. Both of these invitations were accepted gladly and steps are being taken to deal with the matter.

Future of Child Welfare Clinics.—A very comprehensive document, prepared by the Maternity and Child Welfare Group, dealing with the future of child welfare clinics received very careful consideration and the representatives of the Group agreed to take the document back for amendment in accordance with the discussions at the meeting. The document will be submitted to a later meeting of the Council.

Sanitary Inspectors.—The Council was informed that the Ministry of Health had considered the report of the Working Party on the Recruitment, Training and Qualifications of Sanitary Inspectors, and had issued a confidential report containing suggestions for the implementation of the recommendations relating to the constitution of a new examining board. After the Council had carefully considered the suggestions, it was decided to inform the Ministry of Health that whatever constitution was finally decided upon, no single body should be entitled to appoint more than one-third of the total membership. If any adjustment in the suggested constitution was required it was felt that the Minister of Health should be empowered to appoint more independent persons. Other than this the Council had no comments to make on the Ministry's suggestions.

Annual Vital Statistics.—The Council went on to consider a letter from the General Register Office which set out reasons for a proposal to dispense with the publication of Annual Statistics in the form at present published in document SD55. The Council agreed with the General Register Office that the statistics had comparatively little use at the present time and no objection was raised to the proposal.

Certification of Blind and Partially Sighted Persons.—Documents, proposed to be issued by the Ministry of Health and the Ministry of Education, to improve the existing standard of examination and certification of blind or partially sighted persons, were considered. The Council agreed with the proposals in principle but authorised the School Health Service Group to suggest any minor amendments which it considered advisable.

County District Medical Officers.—Reference was made to action taken in certain administrative areas whereby the proportion of time allocated to County District work in mixed appointments was being reduced. The County District Group representatives expressed the view that such action would adversely affect the status of such medical officers. The Council was sympathetic to the views of the County District Group, but it was pointed out that the question of the correct allocation of time for the work of a County District Medical Officer of Health in carrying out his ordinary statutory duties was very difficult to determine as consideration would not only have to be given to the population of the area concerned, but also to the geographical factors, population concentration, and type of area involved. Further consideration will be given to this problem by the Committee which is preparing a document for the Hamilton Committee of the British Medical Association.

Education Grants.—The County Borough Group had asked the Council to give consideration to the action which was being taken in certain areas whereby claims for grants

(*Continued on page* 13.)

THE WAY AHEAD

By JEAN M. MACKINTOSH, M.D., D.P.H., D.P.A.
Administrative Medical Officer of Health (Maternity and Child Welfare), City of Birmingham.

It has been usual for the newly installed President of our Society to express his appreciation of the honour done him by his election. In expressing my own appreciation of the honour you have done me, I do so not only on my own behalf but also on behalf of all the medical officers in our service who are not medical officers of health. I well remember the battle before Dr. Ward became the first assistant medical officer to be appointed President. I am very conscious of the responsibility laid on me in being the first to succeed Dr. Ward in this capacity, after a lapse of eighteen years, and I shall do my best to discharge my duties worthily.

In choosing as the subject of my address "The Way Ahead," I run the very considerable risk of repeating what many others have said already. Yet we are far from reaching a state of even relative stability in the National Health Service, so that it behoves us constantly to re-examine our position in the light of changing events. It is inevitable, too, that I should look on the future from a slightly different angle than that of my predecessors in this office, which may, therefore, lend some small amount of novelty to my remarks.

Looking back over the years since the coming into operation of the National Health Service Act it is interesting to note the changing attitudes among members of the Public Health Service. The first reaction was almost universally of despair, tinged with more than a little bitter mockery, that a piece of legislation which was so much concerned with sickness should be called a National Health Service. This first reaction was that of the idealist or altruist, which, indeed, we all are. We may feel a little diffident about putting it into words but it is self-evident that only those whose eyes are fixed on the stars could survive the buffetings of fate which are too often the lot of the public health medical officer. Our mood of despair was deepened when we saw how poorly we were going to be remunerated compared with our other professional colleagues, for money talks in this imperfect world, and a man's standing is too often assessed by the money he earns. It seemed that the medical administrator was considered to have outlived his day and it appeared to be the general desire that he should pass away by a gentle process of inanition.

Gradually, however, we recovered from the shock and began to reassess the situation in which we found ourselves and to realise afresh the old truth that nothing is ever as bad as it seems and that out of the ruins of the old we might build something new, more fitted to the times in which we live. Fewer among us now are looking backward. A fresh breeze seems to be blowing through the Public Health Service. Your Council is active in their study of the present and future organisation of the National Health Service and of the duties and responsibilities of the medical officer of health in local government. Many of the reforms advocated by our Society, if and when accepted, will take some years to implement. In my remarks to-day I shall be more concerned with the things I think we should be considering in anticipation of these changes.

The question which is uppermost in my mind at the present time is what active steps are we, each one of us, senior members of the Public Health Service, taking to ensure that the junior members of the Service are being given the necessary experience and training to take our place when the time comes. Before trying to answer that question I think we must first have in our minds some idea of what we consider the function of the Public Health Service should be in the National Health Service and we must re-examine our own situation to see how far, even within the limits of the present administrative pattern, we are equipped to discharge these functions. For myself, I have no doubt that in addition to developing our statutory services, we have a duty to arouse the interest of our colleagues in the curative field in the community aspects of the diseases with which they are concerned, to pin-point the problems still to be solved and to provide the basic information as to mortality and morbidity by which they can measure their results. If, in fact, this is the role of the Public Health Service then in its development our Service will become the king-pin of the National Health Service and it follows that the medical officers who work in its ranks will be recognised at their true worth as specialists in community health and in medical administration.

What steps must we take to reach this goal? To quote Sir Allen Daley—"For new advances good reconnaissance is essential." For this development of our work, how many health departments have good reconnaissance? Our reconnaissance is good in relation to notifiable infectious disease, on housing, etc. In other respects, the situation is not so satisfactory. There is a great deal of information about many subjects of great importance to the public health lying dormant in the records of the health department, never used, because it is either not in a form which would make it possible to use it or we lack the staff and time to extract what is relevant. On the other hand, we have records of mortality of various diseases but have little or no knowledge of their incidence. Some attempt is being made to remedy this situation. The Ministry of National Insurance has made a beginning in that we now have some idea of the volume of sickness among the working population in our own and surrounding areas but we do not know the diseases from which they suffer. The Ministry of Health have asked hospitals to provide information to the medical staff of local authorities about their patients on discharge, where this is in the interests of the patients. In due course, we must go further than this—in that we should aim at knowing the total incidence of the major killing or debilitating diseases in our area. It will be a long time, however, before we are able to obtain complete information. In the meantime, I think we should consider whether we have made adequate use of the information already at our disposal. What we need is more and better clerical assistance and, in some instances, we need the skilled help of the statistician in interpreting our findings. In large areas, such as my own, some local authorities are beginning to realise that it is a true economy to make available the services of statisticians and additional clerical assistance. We have the situation at the present time that most of the research in the public health field is being done by people who are divorced from the day to day work of a health department. I do not deprecate what is done by these outside workers. They have their contribution to make and whether or not we agree with their conclusions, the impact of fresh minds should prove a stimulus to our thinking.

While research, as usually understood, whether undertaken by our own service or others, is very desirable, the prime purpose of our collection of information should surely be to enable us to ascertain trends with a view to planning policy or to be in the position to give information to, and on occasion to work with, the curative physicians so that they can measure their progress and plan their future advance in the conquest of disease. This latter aspect is of great importance. Hospital physicians and general practitioners, working in isolation, only get a limited view of the true situation in a community. What we require, therefore, is still more clerical assistance to relieve us of much of the routine work, which many of us still do, and to help us to collate the information on which we must base our observations. We also require the assistance of the statistician to test the validity of our conclusions. The responsibility is ours, however, to plan the resulting policy or to present the facts to the curative branches of the profession. Smaller local authorities may well find it difficult to get the necessary statistical assistance as their areas are too small to give sufficient numbers to make an investigation valid, say, over a single year. To prolong the investigation over a period of years may not present any difficulty with regard to pure research but, from the point of view of planning, may mean that too long a period elapses before the required answer is given. This may be another argument for increasing the areas of health authorities, but local government reform is a thorny problem which will take some years to solve. In the meantime, would it not be possible for the University

Department of Statistics, or of Social Medicine, in the region, to give the necessary technical advice or assistance? Neighbouring authorities often have very similar problems, and co-operation in this way would, I think, result in very valuable pooling of information as to what was going on in the area, as well as making possible worthwhile investigations, providing much useful information. Such an arrangement would not preclude individual investigations by any of the local departments concerned. It would also be of value to the Departments of Social Medicine, particularly in those areas where they are not in close association with the day to day work of a health department, who, in addition to their academic pursuits, should be well informed about the problems of the region in which they work. The enquiry at present going on in Newcastle-on-Tyne, in which the University Department of Paediatrics, the Health Department and the general practitioners are all participating, is one example of what I have in mind. Investigations, at the national level, have only a limited value in relation to the specific problems of an area and the publication of their conclusions is inevitably delayed.

To convince local authorities that expenditure on these lines is profitable and worthwhile we must present our results in a readable form. How few of our annual reports make interesting reading, and who reads them? The faithful editor of the "Medical Officer" seems to keep digging for nuggets, but one has a shrewd suspicion that he finds it a very hard task. We are all familiar with the pressure in the early months of the year to get out the annual report and when it appears, it, too often, shows signs of that mental indigestion from which we have suffered. Yet we have much of interest to tell and even statistics, if properly portrayed, can be made interesting and even exciting.

If the Public Health Service is to discharge the responsibilities I have outlined, we must attract people of good intellectual calibre and to do so, in face of the competition from the curative services, they must receive comparable remuneration. There is more to it than that, however. We must ask ourselves what active steps are we taking to train those who will come after us. Are we so interested in our own career that we take no interest in our junior staff other than to see that they carry out their routine jobs to our satisfaction? It is true we set up committees to examine the course for the Diploma in Public Health from time to time and, if need be, to prepare recommendations for its modification and improvement, but do we, as individuals, consider it part of our duty to give our juniors an opportunity to learn something of administration and of how to handle various situations and to find out where their bent lies? If their bent does not lie in administration, do we actively encourage them to put that little bit extra into their job, whether by means of original investigation, or otherwise, which will lift it out of the routine rut and make it worthwhile? How many of us take them into our confidence in explaining our plans and hopes for the future in relation to the community which we serve? Too often is the attitude taken that theirs is but to do or die—certainly not to reason why. How is it that some health departments seem to be a breeding ground for medical administrators, or seem to go on producing original work and ideas? Are they just lucky in their choice of staff or do the senior officers take just that little bit of extra interest in their junior staff, which makes all the difference? In counties and big urban departments it is especially difficult to keep alive the enthusiasm of those at the periphery. In how many departments is the only contact with the head office the letter which the medical officer receives on the Saturday morning giving the programme of the next week's work? We are apt to forget too quickly that difficult period of transition we all went through when we had to re-orient our thinking from the individual to the community. I have, more than once, defined the function of the medical administrator as someone who creates conditions for other people to do their best work. It would not be a bad idea to give some training in personnel management to those who are in posts of administrative responsibility in the Public Health Service.

Some of you will say to me "We have tried to give our junior officers these opportunities but we have had no response." That may well be true. Not all junior medical officers are swans—we must expect to have our share of the geese of this world, but not more than our share. If, because of our recent difficulties of staff shortage we have been tempted to lower our standards of admission to the Service, and have thus acquired an undue proportion of geese, then we should take immediate steps to remedy the situation. It is better to be short of staff and have them of good quality than be fully staffed with indifferent material. When I was a junior, one had to be qualified at least three years and hold the Diploma in Public Health before applying for any post in the Public Health Service. One of the things we must insist on is that every member of the Public Health Service should hold the Diploma in Public Health or an approved degree in State Medicine. The Diploma in Child Health and the Diploma of the Royal College of Obstetricians and Gynaecologists, admirable in themselves, should only be considered as ancillary qualifications.

One of the most damaging things for the Public Health Service is to appoint the part-time person who wants to do a few clinics. I am not against part-time service but I see no reason why, if anyone wants to do part-time work in the Public Health Service, they should not be required to have the necessary specialist qualifications just as in the Hospital Service they are required to have specialist qualifications if they want to do part-time service as consultants.

If we are going to measure up to our responsibilities in training our successors, the Public Health Service should be so organised that the most junior member should have the opportunity of rising to the highest post—every private should have a field marshal's baton in his knapsack. It seems to me that with our present organisation there is too much possibility of being side-tracked so that able people find themselves up a blind alley from which they cannot return. It is true that some of them prefer to maintain that closer association with individuals which one tends to lose at the administrative level, but at the beginning at least there should be some opportunity to see whether they have any liking or aptitude for administration.

By what avenue should our recruits enter the Service? Are we to scrap the idea of the whole time assistant medical officer doing work in maternity and child welfare clinics and the school health service, and leave it all to general practitioners? I think not. Rather do I think of these medical officers working in closer association with the general practitioners in the area in which they work. The maternity and child welfare medical officer and the school medical officer for an area should be one and the same person. His main concern will be the welfare of mothers and children which, after all, is the foundation of our personal health services. His interests, like that of the health visitor, should now extend to the well-being of the whole community and he should be the local representative of the health department in that area. The amount of his administrative responsibility would vary and would, of course, depend on the area in which he worked. The Cohen Committee on General Practice expressed the opinion that the work of a general practitioner should normally include the practice for his patients of preventive medicine and of health education. The Committee go on to say, however, that it should be possible in group practice for individual members to develop special interests and be in a position to exercise some special skill to a degree which would not normally be expected in general practice. The Committee rejects special payments for particular categories of patients but do approve of specialisation. Why should not the public health medical officer be closely associated with the group practices in his area in this way specialising in health education and community hygiene? Health centres, as originally conceived, are unlikely to take shape in our lifetime. When we look at the matter dispassionately, the reason is obvious. It is one thing to erect buildings; it is another thing to instil in people the desire to work in them. The first step is to establish good will between all concerned. Even when general practitioners get over their suspicion of local authority staffs they still have to get over

their suspicion of local authorities. They do not seem to mind executive councils. I am not one who laments the slow progress in this direction. I feel it is all to the good. I think that if health centres had come into being rapidly, then much that is of value in the public health approach would have been lost. The better path is for general practitioners to learn to work together in groups and to begin to take an interest in the health of their immediate community, as distinct from their individual patients. To enable this to take place there must be a focal point to which the local general practitioner will turn naturally for information, help and assistance. This we have already at hand in our local authority clinics on which we have based medical officers and health visitors. We must, however, have personal contact between all the people concerned. I cannot stress this too often. Telephone conversations or correspondence between two people who do not know each other personally can, too often, lead to misunderstanding. It is not sufficient to say to our staff that we think these personal contacts at the periphery desirable, we must help them by personal arrangements or by letters of introduction to make these contacts. This is time consuming work but well worth doing. This has been done to a great extent in relation to health visitors. It should also be done for medical officers.

I know this co-operation can be brought about because it is beginning to take place in my own area. Not only are the health visitors on excellent terms with the general practitioners, assisting them in every way in their work, but, in two instances, two separate groups of general practitioners in the areas of two welfare centres have asked for discussions with our medical and nursing staff on problems of infant feeding. In each case, the medical officer working in the clinic has led the discussion, which was attended by general practitioners, medical officers and health visitors. In one of these cases, this has been followed by an invitation from the general practitioners to the medical officer concerned to join them at lunch for further discussion. These are very small beginnings but a straw may show which way the wind blows. It will be obvious from this that whatever may have been said elsewhere, I, for one, do not think that the day of the assistant medical officer is over or that the maternity and child welfare centres should be staffed only with health visitors. Nor do I think that the majority of general practitioners have either the time or, in many cases, the habit of mind necessary to undertake the kind of work done at these centres or in the school health service. It is essential, however, that if our assistant medical officers are to fulfil this role, they must be kept in touch with the central office so that they may be up to date in the trends which are taking place and the plans that are being made.

In Circular 118/47, there was a suggestion that assistant medical officers doing maternity and child welfare should have a closer association with curative work in hospital by means of joint appointments. Experience has shown that only in a few instances is this possible. It seems to me that the more fruitful avenue of co-operation is with the general practitioner. The medical officer should, however, have the opportunity, at regular intervals, of attending hospital practice to keep in touch with recent developments.

The public health medical officer has, however, a contribution to make to the hospital service and, in doing so, has also the opportunity to widen his own experience. The recent circular from the Ministry of Health reminded hospitals that it is essential to send prompt information to the medical officers of health on the occurrence, not only of a notifiable disease, but also of any unusual outbreak of communicable disease, and to give the medical officers of health every opportunity and help in investigating such outbreaks when he considers this to be necessary. The Minister also recommends that quite apart from the actual outbreaks of communicable disease, the hospitals should avail themselves of the help the medical officer of health and his staff can give in maintaining the highest standard of hygiene so essential in hospital premises. Some hospitals have only acceded reluctantly to this suggestion. Old ideas about the Public Health Service die hard, yet every hospital management committee should certainly have the benefit of the advice of a public health medical officer with more experience than that of the recently appointed assistant medical officer, but not necessarily a medical officer of health. He could serve usefully on the medical committee of the hospital and in that sense, be a part-time member of the staff as adviser on community hygiene for the hospital, which, after all, is a community, at the same time acting as a line of communication between the hospital and the area which it serves. He would have much of value to give to his medical colleagues with, on the one hand, his close and intimate contact with the work of the hospital and, on the other, the knowledge he can bring of the world outside the hospital to which the patient must return. His presence would facilitate that exchange of information which is so important if a true picture is to be obtained of community progress.

I have an idea that we have a much longer road to travel before we reach our goal in this direction than we have to do with our colleagues in the general practitioner service. It is true that our health visitors are now being accepted much more readily in hospital. Their value to the hospital consultant very soon becomes apparent. As one consultant said to me " When Miss So and So came at first, we wondered what we were going to do with her—now we do not know how we could manage without her." Most consultants are a long way from that point of view in relation to their medical colleagues in the Public Health Service. Many of them find it difficult to realise how much the Public Health Service, and in particular, the public health medical officer, has to contribute to the successful aftercare of their patients, let alone the care of the patient in hospital. We must not blame them for this. The majority of them have keen and enquiring minds interested in research but they are handicapped by the fact that they are only able to survey selected groups. They have not the opportunity of relating their work to the total community experience. It is here that I think we should be able to help them by providing just that information which they require. It is true, as I have said already, that there are wide gaps in our present knowledge, but some of the gaps, even at this stage, could be partially filled either from our existing records or by co-operation with hospitals and general practitioners. I have referred in another place to what has been done in my own city in relation to the maternity services. We have found this to be very well worth while. We are finding, too, that obstetricians interested in some particular facet of their own work, are asking us for information about the community experience in that particular respect, to enable them to see their own problem in its proper perspective. Again—just a small beginning—but I see no reason why, in time, similar results should not be achieved in other directions provided we get adequate clerical, and where we need it, adequate statistical assistance. The information is there in the records of hospitals and of general practitioners. Our problem is to convince those people in whose possession the information lies, that to make it available to the medical officer of health will not be to satisfy his passion to assemble facts, however irrelevant, but will make a real contribution to the value of their work, with resultant benefit to the community. This can only be done by constant personal contact. After all, why should we expect to be taken for granted ? It is only by personal contact that we and the consultants can assess the mental calibre each of the other. In the end, whether we like it or not, our successful collaboration with them will depend on that mutual assessment. Joint committees have their uses but also their very severe limitations. Only by personal initiative in ways such as these can we hope to make real progress.

In this address I have sought to remind you that if the Public Health Service is to play the important part that we believe it should in the National Health Service, then we must attract people of high mental calibre and continue to train them after their entry into the Service. By giving them opportunities to develop their initiative and widen their experience in the ways I have indicated, we will enhance the contribution our Service can make to the general wellbeing of the community and in so doing we will, ourselves, have the satisfaction of knowing that we have done something to inspire our successors with the aims and ideals on which that Service was founded.

SICKNESS AND OTHER ABSENCE AMONG HEALTH DEPARTMENT STAFF*

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In a country such as ours, with an economy based on its capacity to produce and with a highly developed system of social security, absence from work is a matter of prime importance. Ill health is the chief cause of absence from work and to an increasing extent the incidence and type of sickness in the population are being studied in various ways. The Industrial Health Research Board of the Medical Research Council has encouraged the recording of sickness absence in industry and has published several studies of such absence ; the General Register Office has published the records of sickness in the population obtained by the Social Survey carried out by the Central Office of Information and has analysed the records kept by general practitioners under the National Health Service scheme ; the reports of the Ministry of National Insurance give much information on the sicknesses giving rise to insurance claims ; Roberts (1948) has dealt with morbidity records of Post Office employees, while Bransby and Thomson (1949) have studied sickness absence in the Metropolitan Police ; Dennerley (1952) has investigated the effect on sickness absence of the introduction of sick pay schemes ; Pemberton (1949) and Fry (1952) have recorded the illness encountered in general practice and morbidity due to individual diseases such as chronic bronchitis (Goodman *et al.*, 1953) is also receiving attention. The study here described concerns the absence from work of persons employed whole-time in local authority health services during the 10 years 1944–53.

The records for the years 1944–48 deal with the staff of the Health Department of the Borough of Heston and Isleworth, while those for 1949–53 refer to staff remaining with the Borough after the introduction of the National Health Service and to those employed in Local Health Area No. 9 of Middlesex County (Boroughs of Southall, Heston and Isleworth, Brentford and Chiswick). All categories of staff (clerical, nursing, dental, sanitary, day nursery, medical, etc.) have been included. The number of staff covered by the enquiry is 876 (126 male, 750 female) and the length of service of individuals ranges from one month to 10 years.

Absence in any given period may be recorded by (*a*) the number of absences in relation to the number of workers employed and (*b*) the number of days lost in relation to the number of possible working days. Staff changes were so frequent—only 18 were employed for the whole of the period under review—that the latter method only can be employed in the analysis of the records. To arrive at the possible working days for any individual, Sundays, off-duty days, Bank Holidays or days off in lieu were deducted from the total days in employment in each year. Annual, refresher course and conference leave were counted as possible working days. Saturday morning was treated as a whole day but otherwise absence of less than a whole day was not recorded. Sick pay and maternity leave schemes were in operation throughout the 10 years and medical certificates were not required unless the absence exceeded three days.

Initially absence from work has been classified under the following general headings : (i) accident not occurring in the course of work (A), (ii) domestic reasons such as illness of relative, infectious disease contact, etc. (D), (iii) absence of three days or less due to sickness or accident occurring at work (S.S.) and (iv) absence of four days or more due to sickness or accident occurring at work (S.L.). All absence (S.L.), absence (A) if four days or over and some absence (D) were covered by medical certificates but the classification of all other absence was based on enquiry from the employee concerned.

In Table I the loss or working time due to these four main causes is shown. Variations from year to year are to be expected but an average loss of 16 working days (5·1% of 306) per annum seems rather high. Absence to this extent when added to annual leave is of some importance when considering staff establishment. Table II shows that absence from all four causes is greater among women than among men though the disparity in the numbers of each sex does not permit of a firm comparison. Absence is greater among married than among single women and as I (1947) have shown previously, day nursery staff compare unfavourably with other female staff. The influence of age is shown in Table III. In general absence is greatest at the two ends of the age range of 15 to 64 years. Occasional days of absence (S.S.) are most frequent in the 15 to 24 year group, while prolonged absence (S.L.) is greatest in the 55 to 64 year group. The relatively high rate of absence of married women aged 25 to 34 years (Table IV) was due to maternity leave and sickness among their children. Absence

TABLE II

LOSS OF WORKING DAYS IN MALES AND FEMALES BY GROUP CAUSES

Cause of Absence	Percentage of working days lost					
	Male	Female	Female		Female	
	(126)	(750)	Single	Married	Day Nursery	Other
'A'	0·1	0·2	0·2	0·2	0·2	0·2
'D'	—	0·4	0·3	0·6	0·5	0·3
'S.S'	0·4	0·6	0·7	0·5	0·8	0·5
'S.L'	2·0	4·4	3·9	5·5	4·8	4·0
Total ...	2·5	5·7	5·1	6·8	6·3	5·0

TABLE I

LOSS OF WORKING DAYS BY GROUP CAUSES

Year 1	No. of Persons 2	Total working days 3	Working days lost									
			'A'		'D'		'S.S'		'S.L'		Total	
			No.	% of Col. 3	No.	% of Co. 3	No.	% of Co. 3	No.	% of Col. 3	No.	% of Col. 3
1944	169	37889	240	0·6	62	0·2	195	0·5	1768	4·7	2265	6·0
1945	181	43060	207	0·5	151	0·4	160	0·4	2252	5·2	2770	6·4
1946	202	42200	118	0·3	204	0·5	196	0·5	1658	3·9	2176	5·2
1947	217	45345	7	—	132	0·3	236	0·5	1707	3·8	2082	4·6
1948	197	49752	27	0·1	102	0·2	297	0·6	1534	3·1	1960	3·9
1949	386	87969	232	0·3	319	0·4	473	0·5	3369	3·8	4393	5·0
1950	391	95361	36	—	543	0·6	637	0·7	4299	4·5	5515	5·8
1951	357	89026	52	0·1	285	0·3	657	0·7	3801	4·3	4794	5·4
1952	314	79532	52	0·1	257	0·3	502	0·6	3063	3·9	3874	4·9
1953	288	76517	71	0·1	204	0·3	475	0·6	2395	3·1	3145	4·1
Total	876	646651	1042	0·2	2259	0·3	3827	0·6	25846	4·0	32974	5·1

* Presidential Address to the Home Counties Branch, Society of M.O.H., London, July 9th, 1954.

FIG. 1

HIGHEST, LOWEST AND MEAN PERCENTAGE LOSS OF WORKING DAYS, 1944—1953

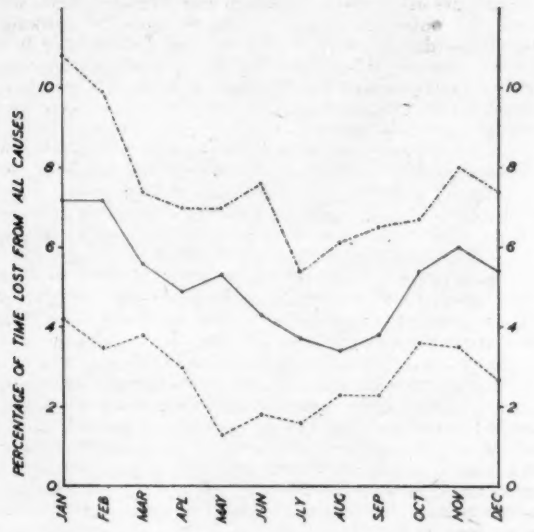

TABLE III

LOSS OF WORKING TIME BY GROUP CAUSES IN RELATION TO AGE AND SEX

Age (Years)	Male 'A'	'D'	'S.S'	'S.L'	Total	Female 'A'	'D'	'S.'S	'S.L'	Total
15–24	1·0	—	0·7	5·5	7·2	0·1	0·3	0·9	4·3	5·6
25–34	—	—	0·5	1·2	1·7	—	0·6	0·7	4·8	6·1
35–44	—	0·1	0·3	2·0	2·5	0·1	0·6	0·4	3·7	4·8
45–54	—	—	0·4	1·2	1·6	0·1	0·3	0·4	4·3	5·1
55–64	—	—	0·2	5·6	5·9	0·3	0·3	0·5	8·2	9·3

TABLE IV

LOSS OF WORKING TIME BY GROUP CAUSES IN WOMEN ACCORDING TO AGE AND MARITAL CONDITION

Age (Years)	Single 'A'	'D'	'S.S'	'S.L'	Total	Married 'A'	'D'	'S.S'	'S.L '	Total
15–24	0·1	0·3	0·9	4·0	5·3	0·1	0·2	0·8	4·1	5·2
25–34	—	0·4	0·7	2·1	3·2	—	0·7	0·8	7·6	9·2
35–44	0·2	0·7	0·5	3·2	4·6	—	0·5	0·3	3·2	4·1
45–54	0·1	0·2	0·5	4·3	5·1	—	0·5	0·4	4·6	5·5
55–64	0·7	0·4	0·7	4·5	6·3	—	0·4	0·3	9·2	9·9

TABLE V

PERCENTAGE LOSS OF WORKING TIME BY SEASON AND GROUP CAUSES

	All Accidents	Domestic Causes	Uncertified Sickness	Certified Sickness
January ...	0·2	0·6	0·9	5·5
February ...	0·2	0·7	0·7	5·5
March ...	0·3	0·5	0·6	4·2
April	0·3	0·3	0·5	3·8
May	0·2	0·4	0·6	4·2
June	0·3	0·2	0·4	3·2
July	0·2	0·2	0·4	2·9
August ...	0·3	0·2	0·3	2·5
September ...	0·3	0·2	0·5	2·8
October ...	0·2	0·3	0·8	4·1
November ...	0·1	0·4	0·8	4·8
December ...	0·2	0·3	0·7	4·3

varies not only from year to year but also from month to month. Fig. 1 shows the highest, lowest and mean loss of time for all causes in individual months. Loss of working time is greatest in January and February and least in August. This variation is due almost wholly to certified sickness as is shown in Table V.

No special study has been made of accidents. No male met with an accident in the course of work but 24 females did. The information available permits the accidents to be placed in the following categories :—

	Accidents at work	*Other accidents*
Falls	10	8
Muscle or joint injuries ...	7	10
Cuts	5	1
Burns and scalds	1	3
Road traffic	1	5
Air raid	—	3

In accidents at work falls occurred indoors more frequently than out of doors, muscle injuries arose in home nurses from the lifting of heavy patients and in day nurseries in the moving of heavy play apparatus, cuts occurred in day nursery kitchens and while repairing day nursery toys, and the only scald happened in a dental surgery. The road traffic accident involved a home help organiser who was knocked off her cycle by a passing lorry. Consideration of the reports submitted on these accidents leaves no doubt that many could have been avoided by the exercise of care and forethought.

Absence for domestic reasons is almost wholly confined to the female staff and is greater among married women (Table II). Loss of time for household removals, contact with infectious disease, etc., was very small and almost all absence in this category was due to illness and/or death of relatives. Among married women the illnesses were usually of husbands or children, while among single women the relatives concerned were generally aged and infirm.

Uncertified sickness absence (S.S.) was greatest in January and least in August and was reasonably constant throughout the 10 years (Table I). Absences of one day showed no special incidence around week-ends, Bank holidays or major sport events.

The duration of certified sickness (S.L.) as measured from the first day of absence to the date of the final medical certificate, showed a wide range. The longest recorded in a male was 299 days due to pulmonary tuberculosis and in a female 356 days due to an operation for varicose veins followed by various complications. The average duration of incidents of certified sickness was 21·6 days for males and 20·5 days for females. Incidents of sickness had a marked tendency to extend to a week and to weekly intervals thereafter up to a limit of five weeks, but this was much less marked in illnesses of longer duration. Of sickness incidents 29·0% were of seven days or less, 59·4% of 14 days or less while 11·4% were of six weeks or more duration. As only one person was discharged on medical grounds during the 10 years under review the proportion of long sickness absence is probably greater than would be recorded in industry. The effect of age on the duration of sickness incidents is shown in Table VI where the older age group have a much higher percentage of long sickness absences.

Grundy (1949), whilst investigating illness in early childhood in Luton, found a large proportion of the sickness,

TABLE VI

DURATION OF INCIDENTS OF CERTIFIED SICKNESS AT AGES 15–24 AND 55–64 YEARS EXPRESSED AS PERCENTAGE OF ALL SUCH INCIDENTS IN EACH AGE GROUP

Duration	15–24 years	55–64 years
Up to 6 days	31·1	18·9
7–13 days	37·1	16·2
14–20 days	14·7	20·3
21–27 days	6·0	2·7
28–35 days	3·0	9·5
Over 35 days	8·1	32·4

measured in days, to be concentrated in a small group of children. Here 113 persons (23 male, 90 female) were employed throughout the five years 1949–53. The average loss of working days due to certified sickness during these five years was 27 for men and 51 for women. Of the men 11 (48%) and of the women 16 (18%) had no incident of certified sickness. The five men with the greatest absence account for 80% of the working days lost by certified sickness in males whereas the corresponding five women account for only 23% of the working days lost by certified sickness in females. Of these 113 persons 32 (29%) lost more time through certified sickness than the average such loss of time for all staff employed during these five years. While these results suggest that illness may be concentrated in certain persons a study of the nature of the illnesses and of the individual records does not lend much support to that view. It is true that in any year certain persons seem to be more susceptible to conditions such as influenza, tonsillitis, etc., but when considered over the five years no firm evidence of concentration of illness in certain individuals has been found. The records do show, however, that in some persons the duration of sickness incidents is persistently longer than the average for similar illnesses.

TABLE VII
PROPORTION OF WORKING DAYS LOST DUE TO CLASSIFIED CAUSES

Special List No.	Cause	Days lost per 100,000 working days		
		Male	Female	Persons
C. 1	Tuberculosis of respiratory system	286	11	60
C. 5	Dysentery, all forms	—	17	14
C. 6	Other intestinal infections	—	4	3
C. 7	Scarlet fever, pertussis, measles, diphtheria, mumps	—	65	53
C. 11	Other infective and parasitic diseases	78	167	151
C. 12	Malignant neoplasms	152	10	35
C. 13	Benign Neoplasms	—	21	17
C. 14	Allergic disorders	5	15	13
C. 15	Diseases of thyroid gland	—	54	44
C. 16	Diabetes mellitus	—	50	41
C. 18	Anaemias	—	51	41
C. 19	Psychoneuroses and psychoses	—	101	83
C. 20	Vascular lesions of central nervous system	—	2	2
C. 21	Diseases of eye	—	31	25
C. 22	Diseases of ear and mastoid process	—	38	31
C. 25	Arteriosclerotic and degenerative heart disease	—	6	5
C. 26	Hypertensive disease	—	33	27
C. 27	Diseases of veins	21	144	122
C. 28	Common Cold	31	124	107
C. 29	Tonsillitis and pharyngitis	56	416	352
3. 30	Influenza	287	671	602
C. 31	Pneumonia	25	54	48
C. 32	Bronchitis	104	212	193
C. 34	Other respiratory diseases	51	101	91
C. 35	Diseases of stomach and duodenum	315	207	227
C. 36	Appendicitis	88	171	156
C. 37	Hernia	—	17	14
C. 38	Diarrhoea and enteritis	63	139	126
C. 39	Diseases of gall bladder and bile ducts	—	18	14
C. 40	Other digestive diseases	38	62	57
C. 42	Diseases of genital organs	15	206	171
C. 43	Pregnancy, childbirth and puerperium	—	288	237
C. 44	Boil, abscess, cellulitis and skin infections	33	83	74
C. 45	Other skin diseases	134	85	94
C. 46	Arthritis and rheumatism	50	168	147
C. 47	Diseases of bones and organs of movement	—	72	59
C. 48	Congenital malformations	51	—	9
C. 49	All other diseases	106	437	377
C. 50	Accidents (occurring at work)	—	85	70

In all studies of morbidity there is the problem of classification of disease conditions. Here the "special list of 50 causes for tabulation of morbidity for social security purposes" in the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death has been used and the results are shown in Table VII. Some of the 50 causes have been omitted from the Table because no such illness was recorded. It should be noted that maternity leave is included in C 43 and that C 50 is restricted to accidents occurring in the course of employment. Taking staff as a whole the chief causes of certified sickness were influenza, tonsillitis and pharyngitis, pregnancy and child bearing, diseases of stomach, bronchitis and diseases of genital organs, but a study of Table VII will show that this order of morbidity is greatly influenced by the preponderance of female staff. Respiratory infections, including influenza, account for a third of the time lost in both sexes. When plotted on a graph the annual loss of working time (absences of three days or more) due to influenza shows a regular wave formation with peaks in 1946 and 1950 and troughs in 1944, 1948 and 1952. The relative importance of any disease as a cause of loss of working days is dependent to some extent on the age of the persons under observation and this is shown in Table VIII.

All the persons included in this survey had been subjected to medical examination or a review of their medical history prior to appointment and therefore cannot be accepted as having any special liability to ill-health. The premises in which they worked varied from adapted to specially designed units and none had low standards of lighting, heating or ventilation and there was no overcrowding. Close proximity to young children in day nurseries and to a lesser extent in clinics may have been a special risk in regard to infectious disease and upper respiratory infection. It is of interest to note that these conditions were most prevalent in the 15 to 24 year age group of the day nursery staff. The greater proportion of the staff had some knowledge of health and the prevention of disease and, however indifferently such knowledge may have been applied to themselves, it probably played some part in reducing the incidence of and the working time lost by sickness.

Logan (1953) in his analysis of general practitioner records found that psychoneurotic disorders accounted for 17·7% in males and 43·8% in females per 1,000 medical certificates issued. Here psychoneurotic disorders were found only in females. Opinions may vary as to what conditions are to be classified as psychoneurotic or psychosomatic, but here "debility," "nervous debility" and "anaemia," not otherwise defined or indicated as secondary to any other condition, were recorded only in females and accounted for a loss of 321 per 100,000 possible working days. In discussing sickness among Post Office workers Roberts (1948) refers to psychological intangibles and states "sick rates are far from being only an index of the incidence of disease *per se* but are, to a great extent, a measure of the state of adaptation of the worker to his or her environment." From personal knowledge of my staff I am certain that some escaped into sickness absence when the essential harmony of home or work was disturbed, but only rarely did the suspicion arise that this was or might be developing into a continuing process. The suspicion of the existence of such factors occurred most frequently in relation to short absences not covered by medical certificates and especially among the younger day nursery staff. It must be admitted that when feeling out of sorts or frustrated the prospect of spending the day among about 50 babies and toddlers is not very attractive. Paines (1954) records a reduction of 65% in sick absence not covered by medical certificates following the introduction of a scheme for referring for special medical examination all staff whose records showed that such absence was unduly frequent. While I appreciate that psychological factors have a bearing on the incidence of uncertified sickness absence and on the duration of certified sickness absence, I find it very difficult to measure or assess the influence of such factors. My personal impression is that they did not unduly influence sick absence among my staff.

Here, in a group of people, selected on medical examination or medical review, working under good environmental conditions, not called upon for strenuous physical effort,

TABLE VIII
PROPORTION OF WORKING DAYS LOST DUE TO CLASSIFIED CAUSES BY SEX AND AGE

Cause (Special List No.)	Days lost per 100,000 working days									
	Male					Female				
	15—24	25—34	35—44	45—54	55—64	15—24	25—34	35—44	45—54	55—64
C. 1	2,234	250	—	—	—	24	7	—	—	—
C. 5	—	—	—	—	—	11	37	31	—	—
C. 6	—	—	—	—	—	4	—	—	—	44
C. 7	—	—	—	—	—	126	30	—	57	—
C. 11	56	—	—	—	703	202	234	183	—	175
C. 12	—	—	—	—	1465	—	—	—	—	190
C. 13	—	—	—	—	—	—	37	35	39	—
C. 14	56	—	—	—	—	27	25	—	—	—
C. 15	—	—	—	—	—	—	—	223	72	—
C. 16	—	—	—	—	—	42	—	—	185	—
C. 18	—	—	—	—	—	54	20	—	142	—
C. 19	—	—	—	—	—	40	190	36	200	105
C. 20	—	—	—	—	—	—	10	—	—	—
C. 21	—	—	—	—	—	27	10	8	87	19
C. 22	—	—	—	—	—	56	38	48	—	—
C. 25	—	—	—	—	—	—	—	—	—	112
C. 26	—	—	—	—	—	—	—	44	139	—
C. 27	—	21	—	58	—	14	83	96	189	1404
C. 28	37	60	26	13	—	217	105	47	24	119
C. 29	158	21	132	20	—	797	272	158	91	179
C. 30	362	229	290	387	124	900	480	429	665	571
C. 31	—	—	—	—	232	—	34	146	—	392
C. 32	167	165	64	95	—	159	184	271	128	855
C. 34	—	—	—	204	—	133	50	133	67	34
C. 35	—	54	42	400	1804	38	150	127	297	1733
C. 36	381	—	—	210	—	262	278	70	7	—
C. 37	—	—	—	—	—	—	—	76	16	—
C. 38	28	93	39	—	232	202	214	66	23	48
C. 39	—	—	—	—	—	—	—	10	87	—
C. 40	—	132	—	—	—	76	42	73	51	22
C. 42	—	51	—	—	—	48	187	160	672	—
C. 43	—	—	—	—	—	145	1006	181	—	—
C. 44	102	54	—	31	—	96	135	19	40	157
C. 45	586	—	300	—	—	159	—	38	25	232
C. 46	65	45	48	51	45	133	166	83	295	149
C. 47	—	—	—	—	—	66	—	169	83	—
C. 48	—	183	—	—	—	—	—	—	—	—
C. 49	—	72	241	85	—	315	541	326	662	721
C. 50	—	—	—	—	—	58	42	21	236	161

working reasonably short hours, generally with some knowledge of health and its maintenance and with no special occupational risk other than contact with young children, the loss of working time due to accident, domestic troubles and sickness has been recorded over a period of 10 years. The extent of absence is not as high as has been recorded in other groups or occupations, but one cannot escape the impression that it is higher than might be expected. The prime purpose of such a survey is to seek for possible methods of preventing accidents and illness and in this respect it appears to me to be a failure. Detailed analysis and study of the records have produced no signpost towards specific preventive measures and one is left with the general principles, already well established, such as good working environment, avoidance of overcrowding and fatigue, health education and the development of a good sense of service. Absence from work is not a purely medical problem but is closely linked with home and work environment and staff management. All factors must be kept under review and every opportunity taken to eliminate adverse influences affecting the group or the individual.

Summary

Loss of working time due to accident, domestic problems and sickness among 876 persons employed in a Health Department during the years 1944–53 has been recorded. The total loss was 5·1% of possible working days.

The records show annual and seasonal variations, but for all three causes absence was higher for women than for men. Absence was greater among married than in single women, but this was largely due to pregnancy and childbearing. The effect of age on the nature and duration of sickness has been studied.

Respiratory infections, including influenza, were the chief cause of sickness absence and psychoneurotic conditions were recorded in women only.

The survey has given no indication of measures which might reduce absence from work.

I have to thank Dr. A. C. T. Perkins, County Medical Officer, for permission to use staff records. Middlesex County Council accepts no responsibility for any statement or expression contained in this article.

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NON-GONOCOCCAL URETHRITIS*

By A. H. HARKNESS, F.R.C.S.

Director, Institute of Urology (Venereology); Physician, London Skin Hospital

Inflammations of the urethra in which the gonococcus is not concerned have a very varied aetiology and may be venereal or non-venereal in origin. The non-venereal causes are : (*a*) trauma (chemical, mechanical or thermal) ; (*b*) non-gonococcal inflammations descending from urethral stricture, glands opening into the urethra, or lesions of the upper urinary tract ; (*c*) local diseases ; (*d*) systemic diseases ; (*e*) the ingestion of certain articles of diet or drugs ; (*f*) metabolic and deficiency diseases ; (*g*) infestations of the urinary tract with protozoa, metazoa or fungi. The time at my disposal, however, is not long enough to allow me to enlarge on these types of urethritis.

The most frequent venereal cause of non-gonococcal urethritis is intercourse with a woman harbouring the infective agent (it can also be caused by anal coitus). This results in a urethritis which is commonly *abacterial* when investigated with the usual staining and culture methods. It should also be mentioned, however, that the disease sometimes becomes evident in the treatment of gonorrhoea after the successful elimination of gonococci. This is usually referred to as " residual non-gonococcal urethritis " and shows that in the first place there was a mixed infection of gonococcal and non-gonococcal origin. When non-gonococcal organisms are present in the secretions in an untreated case the disease is likely to have had a non-venereal origin. However, it should be noted that a diagnosis of bacterial (non-gonococcal) urethritis of venereal origin is rarely made when thorough cleansing of the meatus to remove saprophytic organisms has preceded the taking of specimens for bacteriological examination.

Examination of contacts will often show the presence of a cervicitis and/or vaginitis, but sometimes the signs are so mild that clinically they cannot be regarded as abnormal. I know of one such case that was the source of infection for three men over a period of 12 months. In a recent series of 769 cases there were 151 in which the disease had been maritally acquired, an indication that its common name, " husbands' clap," is sometimes justified. A history of intercourse at the time of a period (which often started during the act) was obtained in 51 cases in the same series.

The incidence of gonorrhoea has decreased considerably during the last few years, coinciding with a marked increase in abacterial urethritis. The report of the Chief Medical Officer of the Ministry of Health shows that in 1952 there were 15,550 fresh cases of gonorrhoea in men at the public clinics while there were 11,552 cases of non-gonococcal urethritis. At Endell Street Clinic at least 70% of patients with urethral discharges are suffering from this disease.

There are two types of primary abacterial urethritis, one acute, the other subacute (the type known as Waelsch urethritis).

Acute abacterial urethritis is characterised by a short incubation period (one to three days) ; profuse, purulent urethral discharge sometimes indistinguishable from that in acute gonorrhoea ; severe pain and frequency of micturition ; terminal haematuria. There is always a generalised cystitis. Indeed, the disease is, in my opinion, similar in all respects to that known to the urologists as abacterial pyuria.

Subacute abacterial urethritis is characterised by a long incubation period of 5 to 40 days, mild subjective and objective symptoms, also chronicity from the beginning. It has a distinct urethroscopic picture in 60% of cases.

Blood-borne complications sometimes arise during the course of both varieties of the disease. There is, for instance, the clinical syndrome (which may be complete or incomplete) known as Reiter's disease, which consists of primary urethritis of venereal origin, bilateral conjunctivitis, polyarthritis, balanitis and sometimes keratodermia blenorrhogica. Cardiac and other manifestations have also been described. It should, however, be noted that there is an almost identical syndrome associated with the various types of dysentery (the primary focus of infection here being the bowel and not the urethra) which is probably the same disease. There are also certain other diseases and reactions due to treatment which may simulate the syndrome very closely. It is interesting to note that although the disease bears Reiter's name following the publication in 1916 of his case (which was of the dysenteric syndrome), six cases of venereal origin had previously been described in 1818, nearly a century earlier, by Sir Benjamin Brodie.

The *aetiology* of abacterial urethritis is still uncertain, but in all probability it is caused by the pleuropneumonia-like organism or a virus. In my experience Giemsa-stained urethral scrapings often show the pleomorphic inclusion bodies of pleuropneumonia-like organisms and sometimes, though rarely, the initial and elementary bodies of the virus of inclusion conjunctivitis. In a recent series cultures for pleuropneumonia-like organisms were positive in 28%, but the rôle of these organisms in the cause of the infections we are discussing is still uncertain. However, their sensitivity to drugs *in vitro* corresponds closely to the clinical response.

Treatment of non-gonococcal urethritis has changed considerably since the introduction of the antibiotics derived from lower-grade fungi, as the sulphonamides and penicillin are ineffective. In my hands terramycin is the drug of choice as shown by the recent series of 769 cases already mentioned. In this the following cure rates were obtained : terramycin 86·5% ; aureomycin 63% ; streptomycin 39% ; chloramphenicol 36%. Terramycin also gave cures in 24 out of 31 cases in which aureomycin had failed, and its apparent superiority was confirmed by statistical analysis in a further randomised series of 156 cases. Terramycin alone is often effective in the treatment of early cases of Reiter's disease, but in established cases better results are obtained when it is combined with fever therapy.

In practice to-day the more expensive drugs are not always available and it is often necessary to use streptomycin. Its action is enhanced if the urine is rendered alkaline.

Before concluding I should like to mention two points worth noting : (1) an abacterial urethritis of venereal origin occurs in association with lymphogranuloma inguinale when there is endourethral penetration of the virus. In such cases the Frei test is positive, also the complement fixation test employing a mouse brain or yolk-sac antigen.

(2) A urethritis, often abacterial but sometimes bacterial and due to *Trichomonas vaginalis*, is not infrequently observed. Such cases are often resistant to treatment. The protozoon would appear to be found more frequently since the introduction of antibiotic therapy and this may indicate a serious problem for the future.

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NON-SPECIFIC URETHRITIS*

By C. S. NICOL, M.D., M.R.C.P.

Venereal Diseases Department, St. Bartholomew's Hospital

Non-gonococcal inflammation of the genital tract which, in the male, is often called " non-specific urethritis " seems to be very prevalent in most parts of the world. In the civilian clinics of the British Isles, " non-specific " urethritis is in incidence second only to gonorrhoea. In the Armed Forces at home, it is now also most prevalent. The condition is a very important cause of ill-health and disability and is certainly a great, and perhaps growing problem. In the past it has been much neglected as a subject for research, partly through ignorance and partly through lack of interest.

* Paper read to a joint meeting of the Medical Society for the Study of Venereal Diseases and of the Metropolitan Branch, Society of M.O.H., April, 1954.

Most clinicians with experience of this condition regard it as being venereal in origin. It is manifested as a low-grade urethritis, which is associated in some cases with local and general complications. It often proves highly resistant to treatment and not infrequently may persist indefinitely in latent form with the possibility of frequent clinical relapse. In female contacts examined there may be neither symptoms nor signs. Clinical examination may, however, reveal urethritis, cervicitis and perhaps proctitis ; if there is also evidence of vaginitis with profuse, frothy and offensive discharge the *Trichomonas vaginalis* is often identified. Infection with a fungus, *Candida albicans*, is sometimes also found, producing pruritus vulvae and vaginitis, with the thick white secretion typical of " vaginal thrush." Ascending infection with inflammation of the uterine adnexa is a possible complication of " non-specific " genital infection and is apt to be a recurring condition. Sterility is a possible sequela.

In taking a medical history from the male patient sexual intercourse is almost always admitted although it is often marital only. The incubation period tends to be longer than that of gonorrhoea and may be up to six weeks. Attention must always be paid to the possibility of urethritis being chemical in origin caused either by a prophylactic urethral instillation or by sensitivity to a chemical contraceptive used by the female contact.

In the investigation of the male with urethritis, the first problem is to exclude gonococcal infection by smear, culture and complement fixation test. This procedure should be a routine. It is generally agreed that there is at present no evidence to suggest that " non-specific " urethritis is in reality a masked gonococcal infection. In fact it is probable that both conditions can occur in the same patient and that certain complications especially arthritis may be due to the non-specific and not the gonococcal aetiology. The relative value of a number of other investigations is difficult to assess, while the main cause of " non-specific " urethritis remains in doubt, but the following methods of testing are in current use.

(1) Examination may be made for bacteria other than the gonococcus, which may predominate in urethral smears and cultures. For instance, the persistent presence of the *B. coli* usually indicates a descending urinary infection and the need for a full upper renal tract investigation. In the majority of patients, however, the presence of bacteria in smears and cultures does not indicate that these are the cause of the urethritis. These may be contaminants or secondary invaders.

(2) Examination may be made for the *Trichomonas vaginalis* by the moist slide method in urethral discharge, urethral scrapings, centrifuged urine, prostatic secretion or semen and also by various cultural methods. In recent years most investigators have demonstrated this protozoon in not more than 5% of patients with " non-specific " urethritis. The *trichomonas* has also been found in the subpreputial sac when balanitis is present (Lanceley, 1953).

(3) Examination may be made for a virus of the lymphogranuloma inguinale-psittacosis group in a Giemsa stained urethral scraping, by intradermal skin testing (Frei test) and by a complement fixation test in blood serum, but a virus cause of urethritis is also rare, occurring in less than 10% of patients. Tests for other virus groups has also been employed with a few positive findings (Willcox, 1954).

(4) Examination may be made for non-specific spirochaetes in the centrifuged urine or prostatic fluid. It has been suggested that certain patients with abacterial pyuria or severe posterior urethritis and trigonitis who respond dramatically to treatment with intravenous trivalent arsenical therapy have an infection with these spirochaetes, but rarely have they been isolated by workers in this country (Czekalowski and Horne, 1951).

(5) Examination may be made for pleuropneumonia-like organisms by cultural methods. Although these organisms can be isolated from the genital tract in a third of all patients with urethritis and can often be found in the genital tract of women with non-specific infection, there is considerable evidence to suggest that they are saprophytic organisms (Nicol and Edward, 1953).

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DISCUSSION

The principal speakers who took part in the discussion are reported as follows :—

Dr. Neville Mascall, President of the Medical Society for the Study of Venereal Diseases, warmly thanked the Metropolitan Branch of the Society of Medical Officers of Health for their invitation to a joint meeting. He considered non-specific urethritis to be nowadays the most difficult problem confronting venereologists. There was great doubt about its aetiology and there were many gaps in our knowledge of the infection and its treatment. Undoubtedly there had been a marked increase in the incidence of non-specific urethritis during the last few years concomitant with the treatment of gonorrhoea with penicillin. As non-specific urethritis has not yet been classified as a venereal disease he wondered how we stood legally regarding the examination of contacts. Quite a large proportion of these had no symptoms and examination revealed nothing abnormal. He thought one was quite justified in treating a wife in spite of negative findings if, as often happened, the husband was repeatedly being reinfected.

Dr. Mascall considered that Dr. Nicol's figure of 5% for *Trichomonas vaginalis* infestation in the male to be unduly high. His own estimate was 2%, though he was aware that some Americans gave a figure of 15%.

Dr. G. L. M. McElligott first referred to the very uncertain bacteriology of the condition and agreed that the problem it presented was insoluble until causal organisms had been identified. He pointed out that, according to the Venereal Diseases Act, 1917, which should not be confused with the Venereal Diseases Regulations 1916, now repealed, only three diseases are recognised as venereal. Even lymphogranuloma venereum, despite its name, is not a statutory venereal disease; neither is non-gonococcal urethritis. Nevertheless, it is generally recognised that the great majority of cases are in fact venereal in origin and it is equally certain that control of and research into the condition will be impossible unless female contacts are traced, investigated and treated.

He illustrated with figures the increase in the clinical incidence of the condition during the last three years and showed how the numbers of new cases were fast overhauling those of gonorrhoea. Since the advent of penicillin, complicated gonorrhea is unusual, but relapsing non-gonococcal urethritis seems to be beginning to take its place as a potential cause of chronic ill-health, and he had noted that salpingitis was not unusual among female contacts.

It would, he thought, be more realistic and more in accord with our knowledge of the natural history of the condition, if patients admitting a recent risk of infection were told that in the doctor's opinion they were suffering from a venereal urethritis and invariably urged to persuade their contacts to attend for examination irrespective as to whether the urethritis proved to be gonococcal or otherwise. He hoped that Medical Officers of Health would have no hesitation in helping to trace these contacts.

Mr. A. J. King said that the true incidence of " non-specific " genital infection was probably much greater than was generally realised. The figures from the Annual Report of the Chief Medical Officer of the Ministry of Health, which had been quoted, referred only to men attending the venereal disease clinics. In all these cases the condition had declared itself with obvious signs of urethritis. It was well-known that, in many cases, the urethral discharge was so slight that the patients remained unaware of the condition, which came to light only on routine examination for some other reason or on the development of a complication. It seemed likely, therefore, that " non-specific " urethritis was a more common condition than gonococcal urethritis, which might be expected to declare itself in nearly all the cases. Because the urethritis was so inconspicuous in some cases it was probable that patients with arthritis or ankylosing spondylitis or iritis, all of which were known complications of this infection, might attend clinics for the treatment of rheumatism or ophthalmic hospitals where the possibility of an association with genital infection might not be considered. It was the fact, also, that gynaecologists saw

many patients with chronic cervicitis, which was commonly due to this infection. Because the patient usually presented without the history of venereal exposure and because there were no specific diagnostic features about the cervicitis, it was to be anticipated that the suspicion of communicable genital infection would not be aroused.

The clinical features of this disease were now well known, but the diagnosis in a typical case was made difficult or impossible by the absence of a known specific organism. It was unlikely that further progress would be made until the causative organism was isolated.

Dr. R. R. Willcox agreed that the first essential was to find the causative organism; although this was a laboratory matter clinical experimental research was still required to prove that non-specific urethritis was indeed transmissible. So far there were five main "suspects": bacteria, spirochaetes, trichomonads, pleuropheumonia-like organisms and virus. Traditionally urethritis had been divided into bacterial and abacterial urethritis depending whether or not bacteria were seen in the smears. Dr. Willcox stated that in his own material urethral cultures gave a similar picture in non-specific urethritis before and after treatment, and also in controls: he did not therefore consider common bacteria to be a usual cause. The same had been noted in America where incidentally two new possible causative organisms had recently been reported.

Those favouring spirochaetes had not been from this country. Buccal and anal coitus had been suggested as responsible. Dr. Willcox could find no evidence of any greater use of these practices in patients with non-specific urethritis than in other patients attending the venereal diseases clinic. Although some had incriminated pleuropneumonia-like organisms Dr. Nicol himself had done much to show that they were probably only commensals. Dr. Harkness was wrong in stating that the drugs which were successful in curing non-specific urethritis were only those with proved action on pleuropneumonia-like organisms. These organisms had been shown to be highly resistant to erythromycin and yet this drug, in Dr. Willcox's hands, had some definite action on the course of the disease.

Dr. Willcox went on to report his own investigations attempting to prove or disprove a virus aetiology of non-specific urethritis. In a study of 234 skin tests for lymphogranuloma venereum, psittacosis and cat-scratch fever, no reactions were noted with psittacosis antigen in either non-specific urethritis cases or in controls. With lymphogranuloma venereum antigen there were 13·1% of positives in non-specific urethritis cases and 4·8% in controls, while with cat-scratch fever antigen there were 12·5% of positive reactions as compared with none in the controls. Some 412 complement-fixation tests for lymphogranuloma venereum and 323 complement fixation tests for enzootic abortion in ewes were also performed (the latter being a veterinary disease due to a virus with similar properties to that of lymphogranuloma venereum). Neither of these two tests gave any increased incidence of positive results in non-specific urethritis cases than in controls although there was striking agreement between them.

A study was made of 1,463 Giemsa-stained scrapings from males with non-specific urethritis, their female consorts and from controls. The results were classified coarsely according to whether blue or red "colonies" or blue or red granules were seen in the epithelial cells or lying free, in an attempt to ascertain whether there was any value in the routine examination of such smears. It was soon noted that the red bodies had no significance as far as non-specific urethritis was concerned and that the investigation stood or fell on the significance of the blue "colonies." These were present in 34·5% of non-specific urethritis cases before treatment, in only 9·9% after successful treatment but in 22·3% after unsuccessful treatment. Moreover they were noted in only 2·5% of 80 controls. It was realised, however, that the controls were patients with *dry* urethrae whereas the urethrae of the non-specific urethritis cases was wet. A further control series of 108 gonorrhoea cases was next taken at a varying time following treatment with penicillin. When these were arranged according to the time interval between the taking of the urethral scraping and the giving of the penicillin injection, it was apparent that at one to three days when the urethra was still wet there was an incidence of blue "colonies" of 21·7%. It was therefore regretfully concluded that none of the bodies studied was concerned with the aetiology of non-specific urethritis.

Finally in experiments involving 1,735 mice, over 100 eggs, some guinea pigs and baboons, it was not found possible to transmit the "virus" into the brains or lungs of mice, subcutaneously into guinea pigs, into the urethra, conjunctiva, or knee joint of baboons, or into the chorioallantoic or yolk sacs of incubating hens' eggs.

Dr. Willcox apologised for giving these findings at some length but much had been said concerning the unknowns in this disease and he did not want the public health members of the audience to think that the venereologists were not trying.

Lt.-Col. B. Levy said that similarly as with civilian incidence the army figures had increased and stressed the difficulty in cure as compared with that for gonorrhoea. He was now seeing approximately two cases of non-specific urethritis to every one of gonorrhoea and had no doubt that it was a venereal disease although the aetiology was a mystery.

He put forward a suggestion that the condition might conceivably be caused by a phase in the life cycle of the gonococcus.

He referred to the relapse rate in treated gonorrhoea in Singapore, and also to the figures in one big army unit where last year non-specific urethritis was more common than gonorrhoea. He referred also to other army commands where non-specific urethritis was also prominent in comparison with gonorrhoea.

CORRESPONDENCE

A Tale of Two Boroughs

To the Editor of Public Health

Sir,—I regret that I am unable to answer all the questions posed by Dr. Smyth (Public Health, September, p. 200) but I would like to do my best.

He asks if the fewer number of routine medical inspections in Ilford is due to the fact that there are fewer school children. The answer is in my paper; in that year there were 23,403 children attending maintained schools in Ilford, and 19,958 in Dagenham. It is true that about one-seventh less routine medical inspections were done in Ilford than in Dagenham. On the other hand there were over twice as many other examinations, mainly follow-ups. I have no means of comparing the actual work of the School Medical Officers in Dagenham and Ilford. I can only present the results of their examinations.

I am afraid I cannot understand the last question of Dr. Smyth's letter. He states: "The question of whether the money and labour involved are justified can only be decided by Dr. Gordon and his staff and the Committees to which he is responsible." Surely we have no latitude in this matter? The School Health Service is a statutory obligation.

Yours faithfully,

I. Gordon,
Medical Officer of Health and Divisional School Medical Officer.

Public Health Offices,
Ilford.

September 18th, 1954.

DINNER AND PRESENTATION TO DR. A. A. E. NEWTH

To coincide with the Annual General Meeting of the School Health Service Group in Manchester (reported on another page) a special dinner was held on June 17th, 1954, at the Grand Hotel so that a presentation could be made to the Group's Honorary Secretary, Dr. A. A. E. Newth, O.B.E., who recently retired as Principal School Medical Officer for Nottingham. The President of the Group (Dr. Mary L. Gilchrist) took the chair, and the President of the Society (Dr. C. Metcalfe Brown) and the Medical Secretary (Dr. F. Hall) were also present. Tributes to Dr. Newth were paid by many of those attending the dinner and the presentation consisted of a cheque to Dr. Newth himself and a very handsome handbag to Mrs. Newth, who was unfortunately not able to be present. Dr. Newth briefly and modestly replied for his wife and himself. The excellent arrangements for the dinner were made by Dr. E. M. Jenkins, Senior S.M.O., Manchester, to whom appreciation was expressed.

Dr. D. A. Smyth asks us to correct an error in his letter published in our September issue. The last sentence of the fourth paragraph should read "and we shall not see the results in fully grown adults before 1967 or 1968."

Council Meeting (*continued from page* 2)

from the Ministry of Education towards that part of the salaries of Medical Officers of Health attributable to School Health Service work were being refused. This action was apparently being taken under Para. 12(a) of Appendix vii of the First Report of the Local Government Manpower Commission. As a result of this action some authorities are seeking the permission of the Ministry to make separate appointments for Medical Officer of Health and Principal School Medical Officer, a division of responsibility which the Council considered very undesirable. It was agreed that a letter be addressed to Ministry of Education drawing attention to this action and asking that further very careful consideration be given to this matter to prevent the control of the School Health Service passing out of the hands of Medical Officers of Health.

Other matters decided at this meeting were the appointment of Dr. C. Herington to serve on the Central Medical Recruitment Committee in the place of Dr. G. F. Buchan, the re-appointment of Drs. J. S. G. Burnett and G. Hamilton on the Royal Sanitary Institute and Sanitary Inspector's Examination Joint Board, and the nomination of Dr. J. F. Macdonald, J. Burman Lowe and Col. E. F. W. Mackenzie as Life Members of the Society.

ORDINARY MEETING, JULY

An Ordinary Meeting of the Society was held at Tavistock House, Tavistock Square, on Friday, July 16th, 1954, at 12.30 p.m.

The Minutes of the Ordinary Meeting held on June 18th were confirmed and signed by the President.

Honorary Fellowship.—Dr. A. A. E. Newth, formerly Principal School Medical Officer, Nottingham C.B., was unanimously elected an Honorary Fellow of the Society.

Elections.—The following candidates, having been duly proposed and seconded, were then elected as Fellows of the Society : Drs. Michael J. Dunn, Winifred M. Markham, Stanley R. Warren and Allan Withnell.

Two nominations for the next election were reported and the meeting then terminated.

ORDINARY MEETING, SEPTEMBER

An Ordinary Meeting of the Society was held in the Lecture Theatre, London School of Hygiene and Tropical Medicine on Thursday, September 16th, 1954, at 5.30 p.m.

The chair was taken by the retiring President, Dr. C. Metcalfe Brown, and there were present approximately 120 members. Several apologies for absence were received.

Minutes of Last Meeting.—The Minutes of the Meeting held on July 16th were confirmed and signed.

Installation of President.—Dr. C. Metcalfe Brown stated that it was with great pleasure that he fulfilled his duty to instal as his successor the first Lady President in the history of the Society and only the second President who was not a Medical Officer of Health. He then invested Dr. Jean Mackintosh with the badge of office and Dr. Mackintosh briefly thanked the Society for the honour bestowed upon her.

Retiring President.—Dr. H. C. Maurice Williams proposed a vote of thanks to Dr. C. Metcalfe Brown, the retiring President, and Dr. H. M. Cohen said that it gave him great pleasure to second this motion which was carried with acclamation. Dr. Metcalfe Brown thanked the members of the Society, and particularly the members of Council, for the support which they had given him during his year of office.

Candidates for Election.—The following candidates, having been proposed and seconded, were elected to membership : *Fellows*—Drs. Elizabeth Capper, R. C. Greenberg, T. B. Harrison, W. E. Holmes, A. W. Iljon, Flora Macdonald, J. M. McEwan, D. H. McFerran, C. J. MacQuillan, Sheila M. Wheeler. *Associate*—B. D. Britten, Esq., L.D.S.

Presidential Address.—Dr. Jean Mackintosh then delivered her Presidential Address, " The Way Ahead." (Published separately in this issue of PUBLIC HEALTH.)

The meeting then terminated.

BRANCH AND GROUP MEETINGS

EAST MIDLAND BRANCH

President : Dr. G. H. Gibson (C.M.O.H., Leicestershire).
Hon. Secretary : Dr. J. A. Stirling, D.S.C. (M.O.H., Chesterfield M.B.).

A meeting of the Branch was held in the Guildhall, Nottingham on Thursday, March 11th, 1954. The President was in the chair and 12 members present.

Dr. Gibson drew the attention of members to the fact that Dr. Newth was retiring and on their behalf expressed the thanks due to Dr. Newth for all the work he had done for the Branch since he became one of the founder members in 1930 and wished him " Godspeed " in his retirement.

A short paper was given by Dr. Barker on "Contact Tracing in Tuberculosis" illustrated with clearly-got-up printed notes. Dr. Barker's paper was much appreciated and after a discussion he was warmly thanked.

Drs. Holderness and Newth then raised points for discussion on " Domiciliary Maternity Grants " and " the Law Relating to the Cleansing of Persons " respectively.

A meeting of the Branch was held in The Guildhall, Nottingham, on Thursday, April 8th, 1954, the President in the chair and 25 members present.

It was unanimously agreed that the names of Drs. Bery and Newth be forwarded to headquarters for proposal to the Council of the Society for Life Membership of the Society.

Dr. George Godber, Deputy Chief Medical Officer, Ministry of Health, who was warmly welcomed by Dr. Gibson, then gave his paper on " The Future of Maternity and Child Welfare." He dealt with his subject in a most comprehensive manner outlining the work of Maternity and Child Welfare since its inception, and suggesting that the time had come when we should examine our schemes and in the light of present day requirements discard old methods which had become obsolete and always be experimenting with new methods which might be of value to the Service in the future. At the close of an interesting discussion Dr. Godber warmly thanked Dr. Gibson.

An evening meeting of the Branch was held in the Health Department, Newark, on Thursday, May 13th, 1954, the President in the chair and 35 members and two guests present.

Dr. G. H. Gibson was unanimously elected as the Branch Representative on the Tuberculosis Group Committee of the Society.

A discussion on " The School Health Service " was very ably opened by Drs. Kind, Margetts and Morgan and that their contributions were much appreciated was shown by the keen and lengthy discussion which followed in which a large number of those present took part.

Refreshments were taken at the conclusion of the meeting and Dr. and Mrs. Buchanan were warmly thanked for making such excellent arrangements, both as regard to the meeting and the refreshments.

NORTHERN BRANCH

President : Dr. W. G. Patterson (S.A.M.O., Newcastle upon Tyne, R.H.B.).
Hon. Secretary : Dr. W. S. Walton, G.M. (M.O.H., Newcastle upon Tyne, C.B.).

A meeting of the Northern Branch was held on Friday, May 28th, 1954—present, the President and 15 members.

Professor Sir James C. Spence. The President referred to the death of Sir James Spence, and as a token of respect the members stood in silence.

Annual Dinner. Although a social success, the Annual Dinner incurred a loss of £3 10s. 5d and it was agreed that the deficit be met from the Social Fund.

Notice of Meetings. The Branch considered a scheme submitted by Headquarters by which notices of Branch meetings would be published in a monthly circular and sent out with PUBLIC HEALTH, thereby effecting a saving in Branch expenditure. It was agreed that present procedure made the scheme impracticable so far as this Branch was concerned.

Papers. Members heard a paper by Dr. W. Walker (Department of Child Health, Durham University) and Dr. S. Murray (Blood Transfusion Service), on " Haemolytic Disease of the Newborn."

NORTH WESTERN BRANCH

President : Dr. S. C. Gawne (C.M.O.H., Lancashire).
Hon. Secretary : Dr. J. S. G. Burnett (M.O.H., Preston, C.B.).

The annual meeting of the Branch was held at Singleton Hall Special School, near Blackpool, on Friday, May 21st, 1954, when 43 members and guests were welcomed by the President.

The report of the Honorary Treasurer was circulated and revealed a loss on the year's working of £10 8s. 11d. The report was adopted.

Election of officers for the year 1954–55 took place as follows :—

President : Dr. A. V. Stocks.
Vice-President : Dr. S. C. Gawne.
Hon. Secretary : Dr. J. S. G. Burnett.
Hon. Treasurer : Dr. J. Yule.
Representative on the Council : Dr. J. S. G. Burnett.
Standing Deputy : Dr. J. Yule.

Eleven nominations were received for 10 seats on the committee and the following were, by ballot, elected :—Drs. H. G. M. Bennett, C. Metcalfe Brown, F. W. C. Brown, J. B. M. Davies, J. G. Hailwood, J. Innes, E. M. Jenkins, M. Sproul, C. H. T. Wade, and K. K. Wood.

The Honorary Secretary reported on the new representation of the Council of the Society and opinions were fully expressed as to the merits of the new arrangements. Members of the Branch serving on the Council were asked to bear in mind the views expressed in the hope that more rational representation might be achieved in the near future.

SOUTHERN AREA

Hon. Secretary : Dr. T. Peirson (M.O.H., Plymouth C.B.).

An ordinary meeting of the Southern Area of the Branch was held on Friday, May 28th, 1954, at the Scott Isolation Hospital, Plymouth. Eighteen persons attended.

The President, Dr. J. Macrae, gave an address on poliomyelitis in particular on the clinical aspect and treatment of respiratory embarrassment. He demonstrated various types of mechanical respirators including both tank types and positive pressure. Dr. Irvine proposed a vote of thanks to Dr. Macrae for the excellent address and to Dr. Johnstone and Matron for the arrangements made at the hospital.

SOUTHERN BRANCH

President : Dr. I. B. Lawrence (M.O.H., Dorchester M.B.R.D.)
Hon. Secretary : Dr. E. J. Gordon Wallace (M.O.H. Weymouth M.B.).

A meeting of the Southern Branch was held at St. Paul's Hospital, Winchester, on Tuesday, April 13th, 1954. The President, 12 members and one guest attended.

(a) It was resolved that the Branch representative be requested to support the candidature of Dr. John Kershaw, Medical Officer of Health for Colchester, as President of the Society for the session 1954–55.

(b) In the absence of Dr. H. L. Cronk, Honorary Treasurer, the financial statement for the year ending March 31st, 1954 was read to the Branch by the Hon. Secretary, who was requested to write to Dr. Cronk to convey the thanks of the Branch for the excellent manner in which he had carried out his duties as Hon. Treasurer during the past year.

Dr. L. J. Bacon then gave a most excellent paper on " Educability " (to be published in the November issue) which was followed by a discussion in which almost every member present took part. On the proposition of the Honorary Secretary, Dr. Bacon was accorded a very hearty vote of thanks not only for his paper but also for having made such excellent local arrangements for the meeting.

A meeting of the Branch was held at Alderney Infectious Diseases Hospital, Poole, on Thursday, May 27th, 1954, the President in the chair and 15 members and five guests attending.

A letter dated May 5th was read from Mr. Bragg informing the Branch that Dr. John Kershaw, after seeking the approval of the County District Group of the Society, had indicated that he wished his nomination as President of the Society for the Session 1954–55 to be withdrawn in favour of Dr. Jean Mackintosh.

Cases of Clinical Interest.—Dr. Wallace described a case of Steven-Johnson syndrome in which the original diagnosis was acute nephritis following scarlet fever one week earlier. The diagnosis of Steven-Johnson syndrome was made apparent when ocular, buccal and vulvar inflammation and ulceration developed within 36 hours of admission. A sustained pyrexia did not react to pencillin, sulphatriad or aureomycin. Pyrexia subsided after 48 hours on aureomycin and cortisone 1 c.c. eight hourly.

Dr. Wallace then described a case of diphtheria—gravis type—in a woman of 40, who had never been immunised and in whom the faucial exudate and signs of toxaemia were very slight.

Dr. Chesney described another case of Steven-Johnson syndrome in a young boy whom he had originally been asked to see as a case of ? smallpox.

Dr. Chesney also described a case of Q fever which he thought might be more common than was realised and he stressed the advisability of sending blood to the Virus Laboratory in cases of p.u.o. with indefinite respiratory symptoms.

Poliomyelitis.—Dr. Chesney then gave a most interesting paper on poliomyelitis beginning with an historical review of the disease and reminding his audience that modern polio is just about 100 years old now. Infantile paralysis was a misnomer.

In his opinion, polio was undoubtedly an enteric infection conveyed from bowel to mouth. As its peak incidence was during the summer and early autumn months he was coming to think more and more that flies might play some part in the spread of infection. The part played by contaminated hands was emphasised. Dr. Chesney quoted the experience of one Canadian town where the incidence of polio had been greatly reduced after an intensive anti-fly campaign in which a 6% D.D.T. emulsion in Diesel oil was used for spraying. He doubted the practicability of passive protection on a large scale by the use of gamma globulin, and felt that active immunisation by means of an attenuated virus vaccine would be a practicable proposition within a few years. Dr. Chesney thought that polio might possibly be the cause of death in a number of infants who were said to die from convulsions.

Dealing with the clinical management of cases, Dr. Chesney said that routine lumbar puncture as a diagnostic measure was strongly to be deprecated. The trauma of the procedure might precipitate an intensive paralysis. In certain cases, lumbar puncture was necessary in order to exclude tubercular meningitis. Purulent meningitis and polio were as a rule easily differentiated.

Dr. Chesney's paper was followed by a discussion in which a great many points were raised including quarantine of contacts, school or class closing, the relatively high incidence of polio in children from " better class " homes being due to their not having acquired a natural immunity owing to their sheltered lives, etc., etc.

After tea, the Ministry of Health film on poliomyelitis was shown and Dr. Chesney subsequently demonstrated modern equipment used in the treatment of respiratory failure in poliomyelitis, *e.g.*, a split-front Both respirator, Beaver respirator, the Oxford inflator, the Clevedon respirator for endo-tracheal respiration, the tipping bed and various forms of suction apparatus.

A hearty vote of thanks was accorded to Dr. Chesney.

WELSH BRANCH

President : Dr. G. McKim Thomas (M.O.H., Cardiff R.D.).
Hon. Secretary : Dr. R. T. Bevan (Dep. M.O.H., Glamorgan).

A joint meeting with the West of England Branch of the Society was held at Cardiff on April 3rd, 1954. After lunch at the City Hall, at which there were forty present, the party proceeded to the Pneumoconiosis Research Unit at Llandough Hospital.

The President welcomed the West of England Branch and recalled the pleasant week-end that the Welsh Branch had had at Bath last year. He then introduced Dr. A. L. Cochrane of the Pneumoconiosis Research Unit.

Field Work of the Pneumoconiosis Research Unit

Dr. Cochrane addressed the meeting on the above subject. He pointed out that the first need in the Pneumoconiosis Research Unit was a satisfactory radiological classification of coal workers' pneumoconiosis. A simple, highly reproducible classification had been evolved which was now generally accepted in Western Europe. A radiological classification was, of course, only the first step, and the Research Unit had been busy since then attempting to relate the classification to more meaningful indices such as pulmonary disability and expectation of life. Such work was not as easy as it sounded ; one had to be very careful to investigate suitable populations. The relationship between *x*-ray category and disability came out very differently according to whether one examined a population of miners applying for pensions, of working miners, or of miners and ex-miners living in a community. The preliminary results suggested that simple pneumoconiosis caused slight disability and did not shorten life, while complicated pneumoconiosis caused severe disability and shortened life. In the investigations the Rhondda Fach population was of great value.

To investigate simple pneumoconiosis, Dr. Cochrane explained that the Unit had *x*-rayed the miners at many collieries, taken detailed industrial histories, and measured the dust concentration on the coal-face. As the result of this work it was possible to suggest that the rate of appearance of simple pneumoconiosis was related to dust dosage by a simple sigmoid curve, similar to that found by toxicologists. This work was now being continued by the National Coal Board.

In investigating complicated pneumoconiosis, the main work had been in the Rhondda Fach Scheme which had been designed to investigate the hypothesis that complicated pneumoconiosis was a tuberculous process modified by the presence of coal dust. In partnership with the Regional Hospital Board an attempt had been made to reduce tuberculous infections as far as possible in the Rhondda Fach and to see whether this would present or reduce the rate of appearance of complicated pneumoconiosis. The

valley with about 30,000 inhabitants was first investigated in 1950–51. The Unit was successful in *x*-raying 89% of the adult population. All cases of tuberculosis found during the survey had been treated in hospital and followed by by a special health visitor when at home. The valley had recently been resurveyed and approximately the same percentage *x*-rayed. The provisional results suggested that there had been a very marked fall, not only in the death rate but also in the prevalence rate and the radiological attack rate of pulmonary tuberculosis. It was hoped, therefore, that it would be possible to test the hypothesis as planned.

Dr. Cochrane said that the success in this community study had encouraged wider interests in measuring the prevalence of other diseases. The prevalence of rheumatoid arthritis in the Rhondda Fach had been measured recently, as had also the blood pressure of a random sample of the population. Studies of the prevalence of diabetes and asthma were now beginning. Tentative plans were being made to study an agricultural area in the same way as the mining valley of the Rhondda Fach. Dr. Cochrane believed that these measurements of prevalence have an immediate administrative value but the main hope was that by finding differences in prevalence it would be possible to obtain some clues to assist in prevention.

Many members took part in the discussion which followed Dr. Cochrane's lecture. Dr. Greenwood Wilson emphasised the importance of this new form of epidemiology. Dr. Cookson and Dr. W. E. Thomas were particularly interested in the incidence of rheumatoid arthritis in miners. Dr. A. R. Culley showed the value of finding the true incidence of diabetes. Dr. Powell Phillips and Dr. Denham discussed the possibilities which can follow Mantoux testing of school children.

In proposing a vote of thanks Dr. Culley commented upon the value of the Rhondda Fach Scheme and its repercussions on the Public Health Service. Dr. Trevor Jones, in supporting the vote of thanks, pointed out the value of field work.

WEST OF ENGLAND BRANCH

President : Dr. J. Macrae (Res. Phys., Ham Green Hospital, Bristol).

Hon. Secretary : Dr. R. H. G. H. Denham (M.O.H., Bathavon, Keynsham and Frome).

A meeting of the Branch was held at the Palace Hotel, Torquay, on Saturday, July 3rd, 1954. The president and 17 members attended, 14 guests were also present.

Bathing and Bacteria

Dr. Brendan Moore, director Public Health Laboratory, Exeter, gave a paper with the above title. He said that the health risks which had been ascribed to bathing could be broadly classified into (1) diseases due to bathing in sewage-polluted waters where the infecting agent was an organism present in sewage, *e.g.*, an enteric bacterium or poliomyelitis virus; (2) diseases associated with swimming pools which were mainly infections of the upper respiratory tract and conjunctiva; (3) a miscellaneous group including lupus and other mycobacterial infections, leptospiral infections and schistosome dermatitis. Typhoid fever was the only serious disease with a well-established relationship to bathing or accidental immersion in sewage-polluted waters, particularly where untreated sewage was discharged into confined harbours in which adequate dispersal by currents could not take place. There was no good evidence that poliomyelitis was a major risk of bathing in sewage-polluted waters, but with the increase in incidence of this disease it might well become so. With swimming pool infections it was difficult to assess the importance of such factors as contiguity of other bathers, the mechanical dissemination of the bather's own bacterial flora into the nasal sinuses, the removal of protective secretions from the respiratory mucous membrane, and chlorine irritation. These factors were probably of greater epidemiological importance than the presence of pathogenic bacteria in the swimming pool water.

Although there was no good evidence that bathing in sewage-polluted water was a serious risk to health, the medical officer of health of the coastal town should nevertheless not ignore the problem. The discharge of sewage into coastal waters was almost the only instance in civilised countries of the deliberate exposure of a population to contact with excretal organisms, and could not be accepted in principle however harmless it appeared to be in practice. A plea was made for the collection of more epidemiological information in coastal resorts on the possible hazards of bathing, including minor gastrointestinal disturbances as well as more serious disease. The medical officer of health should also at least know the main principles of sewage disposal by dilution, with particular reference to the biological factors affecting the survival of sewage organisms in sea-water. Only by combining more detailed epidemiological enquiry with further studies on the presence and fate of pathogenic bacteria and viruses in sea-water could a rational policy on this subject be formulated.

A full discussion followed in which Drs. Midgley, Whitman, Doyle, Reynolds, Meredith Davies, Perry, Davies, and Solomon took part. Dr. Moore was thanked for his able address by Dr. Irvine.

It was agreed unanimously that Dr. Davidson, County M.O.H., Somerset, and Dr. Cookson, M.O.H., Gloucester C.B., continue to represent the Branch on the Medical Advisory Committee of the South West Regional Hospital Board.

The Hon. Secretary referred to the retirement of Dr. J. B. Lowe, C.M.O.H., Wiltshire, and it was decided that Dr. Lowe's name be submitted to the Council for recommendation for life membership of the Society.

The following officers were appointed for the 1954–55 session:—

President : Dr. L. Solomon.

President-elect : Dr. R. C. Wofinden.

Secretary and Council Representative : Dr. R. H. G. H. Denham.

Hon. Treasurer : Dr. J. M. Cormack.

Representatives on the Tuberculosis Group : Drs. R. L. Midgley and J. Macrae.

YORKSHIRE BRANCH

President : Dr. W. G. Evans (M.O.H., Scarborough, M.B., A.C.M.O., N. Riding).

Hon. Secretary : Dr. H. L. Settle (M.O.H., Doncaster C.B.).

An ordinary meeting of the Branch was held in the Department of Preventive Medicine and Public Health, 32 Hyde Terrace, Leeds on Friday, March 26th, 1954, 17 members being present.

Dr Bertram Mann, Consultant Chest Physician, Halifax gave an address entitled "Clinical and Public Health Tuberculosis Problems in the United States and Canada." The speaker had recently visited the United States of America and Canada whilst holding a travelling scholarship and he gave an interesting and amusing account of his experiences in hospitals, clinics and sanatoria in the course of his extensive travels.

Among the points to which he drew attention were the extent to which mechanisation has been introduced into these institutions; for the handling of patient's food, in the laundry, and even in the laboratory where the preparation of pathological material for microscope section cutting is now carried out over-night automatically. Diagnostic facilities are provided on a lavish scale in all sanatoria and those with more than 200 beds have respiratory physiology units, vertical tomographs and electrocardiographs. There is a high degree of dilution in hospital nursing staffs, these comprising a nucleus of highly trained nurses and the remainder untrained. The extensive legal powers for the control of tuberculosis which have been introduced in Ontario were dealt with in detail.

A number of members took part in an interesting discussion following the paper and Dr. Lyons, Divisional M.O., Calder Valley Area, West Riding, proposed a vote of thanks to the speaker for his interesting and amusing discourse.

A business meeting of the Branch was held on April 23rd, 1954, at the Department of Preventive Medicine and Public Health, 32 Hyde Terrace, Leeds, 17 members being present.

A number of domestic matters were discussed at length. Difficulties encountered by medical officers of health in dealing with milk supplies found to be infested with brucella abortus were considered and the secretary was asked to obtain more information on certain aspects of the problem.

The question of amending the meeting day for the Branch was also discussed but a decision was deferred for the views of members to be obtained by the Secretary.

An ordinary meeting of the Branch was held on May 28th, when Dr. A. K. Black, Assistant Medical Officer (Maternity and Child Welfare), Sheffield C.B., addressed members on "The Results of an Analysis of the Reasons why Mothers attend Maternity and Child Welfare Clinics and their Reasons for Discontinuing Attendance."

Dr. Black reviewed the development of the maternity and child welfare services in Sheffield, pointing out that in 1900, when the infant mortality rate was 200, women sanitary inspectors were appointed in the city to give practical advice and sympathetic encouragement in the home. In 1952 the infant mortality rate had dropped to 24.

The investigation was carried out at four centres which gave a representative cross-section of the various social classes in the city. Approximately 80% of mothers attended for advice, weighing of the child and proprietary dried milks, while only seven mothers out of 1,000 had attended in order to obtain food

at reduced rates. Whilst the number of new cases and the total attendances at the centres throughout the city have decreased since the introduction of the National Health Service in 1948, attendance of children during the first and second year of life has been well maintained and the average number of attendances per child per annum appears to be increasing. On the other hand the number of pre-school children over two attending clinics is not showing similar increases. A scheme whereby pre-school toddlers are invited to periodic medical examination by appointment has been introduced and is becoming popular.

The reasons given by mothers ceasing to attend clinics are, as would be expected, varied. Lack of time or unwillingness to attend are among the commonest reasons given. The majority of mothers felt the need for guidance during the child's first year of life and once a child is taking an ordinary diet and in good health the mother ceases to require help and discontinues her visits.

Dr. Black also included in her paper details of a survey of 200 mothers with children under five years of age who had never attended a child welfare clinic and pointed out that the health visitors had great difficulty in finding examples for this enquiry.

An interesting discussion took place at the conclusion of the paper in which a number of members took part and a vote of thanks was proposed by Dr. A. Marshall, Deputy D.M.O., Brighouse and Elland, and seconded by Dr. E. L. Simon, Sen. A.M.O., York.

Annual General Meeting

The Annual Meeting of the Branch was held at the Department of Preventive Medicine and Public Health, 32 Hyde Terrace, Leeds on Friday, June 25th, 1954, at 5.30 p.m. The minutes of the last meeting were read and confirmed.

Members then proceeded to the election of Officers for the 1954/55 Session, the following being elected :—

President : Dr. C. G. K. Thompson.
Vice-Presidents : Dr. W. G. Evans and J. Wood-Wilson.
Honorary Treasurer and Secretary : Dr. H. L. Settle.
Branch Council : Drs. E. C. Benn, J. F. Caithness, M. Hunter, J. Lyons, A. Marshall, G. Mayhall, G. A. W. Neill, D. D. Payne and A. L. Taylor.
Representative of the Branch of the Council of the Society : The Honorary Secretary (The President to act as deputy).
British Medical Association Branch Council : Drs. W. G. Evans, G. A. W. Neill, A. L. Taylor and C. G. K. Thompson.
Tuberculosis Group Committee : Drs. S. J. Wood-Wilson and G. A. W. Neill.
Honorary Auditors : Drs. C. W. Dixon and D. D. Payne.

The meeting then considered various domestic matters including the replies received to a questionnaire sent to all members regarding Branch activities and the present meeting day. It was decided that the only change to be made in the existing arrangements was the holding of one, or possibly two, meetings during the session on Saturday afternoon.

On Friday, July 16th 1954, a party of members visited Spofforth Hall, a Rehabilitation Centre for Problem Families, administered by the Elizabeth Fry Memorial Trust.

Members were first given a brief account of the history of the project and were then conducted round the premises. Following refreshments an interesting discussion took place with members of the staff.

SCHOOL HEALTH SERVICE GROUP

President : Dr. Mary L. Gilchrist (A.D.M.O., Essex).
Hon. Secretary : Dr. A. A. E. Newth, O.B.E. (formerly P.S.M.O., Nottingham C.B.).

Special General Meeting

A Special General Meeting of the Group summoned by notice sent out on December 31st, 1953, was held in the Old Library, B.M.A. House, London, on January 22nd, 1954, at 4.25 p.m. The President was in the chair and about 40 members were present. The business of the meeting was to consider a proposal that the first paragraph of Regulation 3 of the Group Regulations be altered to read :—

> " All Members of the Society whose names appear on the Roll of Members of the Group held by the Secretary of the Society on December 31st, 1953, are members of the Group."

The proposal was put to the meeting and it was unanimously Resolved that it be adopted.

Ordinary Meeting

An Ordinary Meeting of the Group was held in the Old Library, B.M.A. House, London, on Friday, January 22nd, 1954 at 4.30 p.m. The President was in the chair and about 40 members were present.

New Members for Election. The following fellows of the Society was unanimously elected as members of the Group :—Drs. Isidore Ash (Newcastle under Lyme C.B.), Alastair Cann (Hull C.B.), Peter D. Cannon (Lancs. C.C.), Margaret Capra (L.C.C.), John L. Cotton (Bury C.B.), James W. B. Douglas (Usher Institute, Edinburgh), Ethel A. Fisher (Reading C.B.), Reginald D. Gross (Middx. C.C.), Maragaret A. Hauxwell (Kent C.C.), Frederick M. James (Major, I.A.M.C.), Barbara Jones (Cheshire C.C.), Edith Kyle (Kent C.C.), Jean McInnes Dixon (Ayr County), Margaret M. R. Macleod (Birmingham C.B.), Joyce B. Mole (Birmingham C.B.), Rosa M. Piggot (Reading C.B.), William A. Pollitt (Lancs C.C.), Lorna M. Rozner (Jarrow C.B.), Mary E. Seaton (Birmingham C.B.), C. Milliken Smith (Northants C.C.), Honora J. Twomey (Huddersfield C.B.), John Yule (Stockport C.B.).

Juvenile Delinquency

A discussion on juvenile delinquency was opened by Dr. W. J. Pierce who dealt with the causes, Dr. G. S. Robertson on prevention and educational treatment, and Dr. A. Smallwood on the Bristol Conference findings. There was a most lively discussion during which members dealt with varying aspects of the subject.

Joint Meeting of the School Health Service and Services Groups

A joint meeting of the School Health Service and Services Groups was held on Friday, April 23rd, 1954 at 4.30 p.m. in the Lecture Theatre of the London School of Hygiene and Tropical Medicine, London, to discuss " The School Leaver in Relation to his Future in the Services and in Industry." Forty-five members of the two Groups attended.

The chair was taken by Dr. Mary L. Gilchrist, President of the S.H.S. Group supported by Dr. G. M. Frizelle, President of the Services Group. The opening speakers were Dr. H. M. Cohen, Principal School Medical Officer, Birmingham who dealt with " The School Leaver—The Final Phase," Lieut. Colonel J. B. M. Milne, O.B.E., R.A.M.C., Advisor in Physical Medicine to the War Office, on " The Substandard Recruit," and Dr. J. N. Macdonald, Senior Medical Officer, Lever Bros., Port Sunlight, Ltd., on the " Young Person in Industry."

Dr. Frizelle welcomed the meeting to the School and expressed his regrets at being unable to stay for the discussion owing to a previous engagement.

The School Leaver—The Last Phase

Dr. H. M. Cohen said that the term " vocational " was familiar to all concerned with the School Health Service. On the other hand it seemed rather strange that there should be any relationship to preparation for the Services. Yet in a wide view the claim seemed evident. He reminded his audience that when the School Medical Service, as it was then known, came into being in 1907 partly as a result of the serious lack of fitness among would-be recruits for the South African War, it was emphasised that it aimed at not merely a physical and anthropomorphic assessment or record of the defects disclosed by medical inspection, but also at the physical improvement and, as a natural corollary, the mental and moral improvement of the coming generation.

In these early days, when children were suffering from the results of diseases which were now prevented, when they were thought of as miniature adults and were sent out too early to work with no consideration as to their capabilities, medical examinations revealed a large catalogue of defects and diseases. In later years there had been further restatements of the aims of the service and this evolution was continuing. The change of name to " the School Health Service " was of significance and importance.

During the last phase of school life, the main aim of the service—the promotion of health—became more evident. In curative medicine there was a tendency to equate health with the absence of disease and the immense positive contribution which health could make to the happiness and effectiveness of the individual and to the integration of his personality was too often forgotten. Frequently there was concentration on the remedying of disease rather than on the creating of conditions for the best of life.

At the present time, the school medical officers alone dealt with an unselected child population. They found that many children who complained of nothing, were, in fact, in far from a satisfactory state of health, and that in order to find the root of the trouble and to be of help, they built up a complete picture of the child in his total environment. This meant piecing together information derived from a variety of sources, such as parents, teachers, psychological tests, weight and measurement charts, with assessments of reports on home conditions.

Dr. Cohen sketched the work of the School Health Service laying particular stress on health education which it had to

promote and integrate. In the period under consideration, the child was physically going through the third springing-up period and physical education was given the same consideration. Physical education in schools was not now just physical jerks—it was concerned with the development of the individual child. The aim was concerned with the quality of movement and with improved standard of physical skill. Accordingly a gamut of physical activities was provided. School milk and meals had done much to improve the physique of the children.

Turning to the substandard child, Dr. Cohen said that he had in mind the special training which the service provided for such recruits and he mentioned the proposals to provide special residential treatment for this type during the last year in school, which has unfortunately been turned down by the Ministry of Education.

The importance of mental hygiene, the maintenance of mental health and the prevention of mental disorder, in this adolescent period was properly recognised. One-third of the discharges from the Army on account of illness were through mental ill-health, so it was particularly important that the ideas of mental health practice should be properly applied. Group morale in the classroom as in the Services was of the greatest importance. Cases of maladjustment called for skilled treatment. The educationally subnormal child was also being given very close attention.

Dr. Cohen then touched on the stages of vocational guidance by school doctors as the importance of the information which they could give in respect of suitable employment was increasingly recognised. The Ince Report stressed this positive approach by which all children should be helped, guiding into vocation not only the handicapped pupil, but also all classes of school leavers. It was essential, however, that this information should be interpreted by the school medical officers.

The Periodic Medical Inspection which formed the basis of the work of the Service was a full audit of the child's general condition, and in both the schools and clinics there was also a continuous surveillance of all children throughout their school life. He regretted that the full histories and records of the children were not used by the doctors who saw the children after they left school, except in a few instances. Incidentally it had been hoped to make these records even more complete by the inclusion of Pulheems profiles, but it seemed that this was not practicable.

In conclusion Dr. Cohen mentioned the close attention given to the needs of the delicate and handicapped child, and for every child the possibility of B.C.G. vaccination and of *x*-ray of the chest, and attention to colour discrimination as well as acuity of vision, hearing, teeth, foot health and speech.

The Substandard Recruit

Colonel Milne defined the substandard recruit as the youth who, although free from any active disease or the effects of past disease or injury, was yet incapable of normal basic training in the Army.

The total annual call-up for National Service was about 120,000. Of these, 20,000 or 18.2% were rejected for all causes. Another 18·0% were accepted in low medical categories and were given modified training; they were employed in less strenuous duties suitable to their limited capacity. A second group of men, although they would have been unfit to respond to the very strenuous training of war years could accept the less urgent and strenuous basic training of the present peace period.

There was a third group, however, who although likely to break down in training as they entered the army could with a month's special training reach a standard adequate for full training. These men were salvaged by means of conditioning courses run at Command P.T. Schools under a P.T. Officer and experienced P.T. Instructors. Of 1,276 men put through this course in 1953, 50 were down-graded, 7 were discharged, and 1,219 were returned as fit to fight in infantry—viz., nearly two battalions put into the field instead of drifting into sedentary jobs.

This third group comprised men of various types :—

(1) *Muscular Inadequacy*. Chiefly in the upper extremities, the result of lack of physical work and nothing else. They might be thin or fat.

(2) *Faulty Posture*, without bony cause such as short leg or adolescent kyphosis. They showed a timid round back with backward carriage of the pelvis or aggressive lordosis with a forward carriage of the pelvis. Their condition was a reflection of a past or present psychological state which had become a habit. The body worked at a mechanical disadvantage and fibrositis of postural fatigue or repeated minor traumata was common. The Army treated them by correcting the position of the head, and, as in the decebrate cat, the body dropped into the corerct line. The psychological state improved with body posture and vice versa.

(3) *Poor Co-ordination* with or without poor musculature—the awkward, clumsy chap whose agility was negligible. He could not march or climb a rope or wall. In his case physical activities to build up an adequate kinaesthetic sense was all that was required.

(4) *Excessive Dyspnoea on Exertion*. The lad who never played games and always travelled by bus.

(5) *Iatogenic Diseases*. This group of weak hearts, backs, and stomachs, while not common, produced serious limitation of function in the individuals concerned and provoked many administrative enquiries. Effort syndrome in mild degrees was the commonest type seriously tackled on Conditioning Courses. They could be cured but it took much time and patience. These conditions, Col. Milne said, were due to a careless statement by a G.P. or school doctor banning the child from physical activity after illness or injury for an indefinite period. Doctors' children were the most difficult to cure.

(6) *Falling Sickness*.—Blackouts, vaso-motor instability, varying from spots in the front of the eyes to syncope and complete unconsciousness, sometimes with urinary incontinence. This was cured in 100% of cases by a week's general training including quick changing of posture plus static contraction of the muscle groups of the legs while standing. A few broke down again if the will to serve failed.

(7) *Painful Feet*. A vast subject. The Army did not worry about the appearance of the feet, mobility being the most important factor. Children rarely complained, but, if caught early, a commencing acquired deformity could be corrected, whereas at National Service age correction was impossible. There were two important points that must be checked—fitting of footwear and correct posture. The former required education of parents as to the damage done by ill-fitting footgear, particularly too tight shoes and socks. The only practical solution was the production of a shoe with short life, costing about five shillings and the thorough grounding of adolescents in foot care. Doctors needed education in this as very few knew much about feet and most were incapable of examining them properly.

Flat-foot was not a disease; it was a deformity secondary to something else. Any child that was tired, particularly one convalescing from a febrile illness, would on standing allow the feet to pronate ; the calcaneus slipped into valgus and the forefoot everted; at the same time the femora rotated medially (squinting knees) and the gluteus maximus lost tone with changes in spinal posture. This stance too frequently became habitual and in spite of faradic footbaths and foot exercises no improvement occurred. The boy on leaving school found that he drifted into sedentary employment. Such a recruit if one excluded the one with the hypermobile flat-foot with short tendo Achillis could be relieved. In front of the mirror he was shown how turning his knees cured his flat-foot. He was then made to stand for two hours. This gave him backache but not foot ache. He knew he could prevent his feet from becoming painful and he knew that the Army knew it. He carried on. Foot exercises except as a part of a general habilitation programme were largely a waste of time.

(10) *Other Cases*. Men whose history was incompatible with their physical signs.

One factor common to the majority irrespective of which of the above groups they belonged, was lack of self-confidence. The training was designed to prove to each individual that he was a normal healthy youth, capable of and even enjoying hard, physical work. The work most of it in game form, was planned to make them stiff for the first week or fortnight and then the tempo eased off to let them feel the benefit of it. The results were astonishing. Their body build remained the same but their physical performance was markedly improved. Their morale was right up and they had a " bash." Those with mental dullness, obesity, physiological under-development and marked psychoneurosis did not respond. Other failures were due to some previously undetected organic disability or to the Army being enable to cut though the mother's apron strings. Col. Milne acknowledged that in some cases the physique of a youth deteriorated after he had left school, but those he had been discussing were poor specimens at school. " If in a month the Army can produce this transformation surely an adequate physical education programme at school could produce a good physique, but perhaps still more important, such enjoyment of some physical activity that the adolescent would continue to participate with some encouragement if necessary from the local youth clubs and prevent this shortage of fit men."

The Young Person in Industry

Dr. J. N. Macdonald, commenting on the improvement in interest in the health of young people, said that the problems of industry were the same as those of the schools and of the services. The improvement in the heights and weights of entrants into industry had been recorded; teeth were better, but they were still not as good as they might be. Many showed defects of vision and 73% of the girls had infected heads. Industry was particularly

interested in the emotional life of these young people. Leaving school and entry into industry was a major event in the emotional life of a child. The aim of industry was to maintain a group of happy loyal hard workers who took a pride in their job. With the growth of independence there was a danger of their developing fear and uncertainty. Whereas in their last year at school they might be big and important, in industry they found themselves to be nonentities. Those who came from good schools where pupil-teacher relationship had been encouraged found little like it in industry.

Dr. Macdonald then went on to describe in some detail how his firm tried to overcome these difficulties. The personnel officer went into the school and gave talks on the life in industry and the older boys and girls were encouraged to visit the factories to see them at work. The interview with the entrant was arranged on as friendly an atmosphere as possible and the interests of the young people and their futures were considered. A detailed medical examination with *x*-ray was carried out. If more medical information was needed, the general practitioner and the school medical officers were approached. It was to be regretted, however, that it was not always easy to get this information. The entrant then went to an introductory course and there were talks with the factory supervisor. This introduction to the job was important, but it was not always done as well as it might be. Later the entrant was seen by a member of the personnel department who discussed his future and what he wanted to do in the County College. Dr. Macdonald regretted that it was found that among the apprentice there were more vacancies than people to fill them owing to the small difference between the wages of skilled and unskilled workers. Before the young person left to go in for his National Service he was given an opportunity of going round his future unit to see what the service would be like. The whole aim was to ensure a happy organisation in industry.

During the lively discussion that followed, one lady school doctor pleaded for more co-operation between the factory and school doctor over verminous conditions of older girls, another school medical officer asked how the school could break the over-dependence of the child on his mother while at school, and a third pointed out the difficulties of getting this done in day schools. One speaker emphasised the importance of respecting the confidential nature of school reports and of making sure that an unfavourable school record did not result in a child being rejected by a firm. Dr. Macdonald, however, assured the audience that the school reports were asked for only after the child had been accepted. He also said in answer to another question from a member of the Services Group that the Pulheem system was not generally acceptable in industry. Another speaker stressed the importance of the School Health Service tackling the problem of the child who turned out later as a substandard recruit.

In closing the meeting, the chairman, Dr. Mary Gilchrist, thanked the various speakers for the valuable contributions they had made to this most important subject.

Annual General Meeting

The Annual General Meeting of the Group was held in the Town Hall Annexe, Manchester, on Thursday, 17th June, 1954 at 4.30 p.m. The President was in the chair, supported by the President of the Society, Dr. Metcalf Brown. Over 40 members were present.

The Minutes of the last Annual General Meeting, (published in PUBLIC HEALTH October, 1953), were approved and signed.

The Honorary Secretary reported that since the last Annual General Meeting, Ordinary Meetings had been held on 16th October, 1953, when Dr. Gilchrist delivered her Presidential Address on "The Changing Face of School Medicine" (PUBLIC HEALTH, May, 1954); on January 23rd when a discussion on Juvenile Delinquency was opened by Drs. Pierce, Robertson and Smallwood, and on April 23rd when they were joined by the Service Group to discuss "The School Leaver in Relation to his Future in the Services and in Industry." A very successful Joint Meeting with the Association of Medical Officers of Schools was held at the invitation of the Association to hear Dr. Henderson on his visit to America (PUBLIC HEALTH, March, 1954). A Special General Meeting had also been held on January 23rd, 1954, when a slight alteration in the Regulations of the Group was decided upon.

The Council of the Group had met on five occasions and had dealt with a number of matters of concern to school medical officers such as a suggested revision of Form 4 HP, accommodation for medical inspections in schools, the desirability of periodic medical inspections, and representatives had attended at the Ministry of Education to discuss with Dr. Henderson and his lay colleagues certain points about Form 4 R.T.C. After conferring with representatives of the the M. & C.W. Group they had submitted comments on Cruelty and Neglect of Children for the British Medical Association and the Magistrates Association. They had also considered health education for the prevention of head lice in children and had urged the reviewing of the salaries of senior and (assistant) school medical officers.

A very successful refresher course for junior S.M.O.s had been held in January, 1954, and arrangements had been completed for a course for senior school medical officers in Birmingham in September next.

The membership of the Group was nearing 800.

The Honorary Treasurer then presented his report on the finances of the Group.

Election of New Members

The following Fellows of the Society were unanimously elected as members of the Group :—Drs. Audrey K. Arnold (L.C.C.), Jane J. Connolly (Preston C.B.), Carmel P. Dooley (Nottingham C.B.), Jessie Edwards (L.C.C.), Ruth M. Howitt (L.C.C.), Eleanor J. More (Nottingham C.B.), Constance S. Pimm (Kent C.C.), Myrtle V. Richards (Warwickshire C.C.), Rachel F. E. Spicer (L.C.C.), Ronald G. Sprenger (Nottingham C.B.), Walter P. B. Stonehouse (West Riding C.C.), Tom A. J. Thorpe (Manchester C.B.), James H. Walsh (Preston C.B.).

Election of Officers and Council

The following elections were made :—

President : Dr. W. J. Pierce.

Past-Presidents: Drs. Mary L. Gilchrist and C. L. Williams.

Hon. Treasurer : Dr. H. M. Cohen.

Hon. Secretary: Dr. A. A. E. Newth.

Assist. Hon. Secretary: Dr. C. W. Anderson.

Hon Auditors: Drs. V. H. Atkinson and E. D.Irvine.

Representatives on Council of Society: Drs. Cohen, Pierce and Newth.

Group Council:—Drs. V. H. Atkinson (Bradford C.B.), J. E. Cheesman (Kent C.C.), R. W. Eldridge (Lancs. C. C.), J.Ferguson (Bentley U.D.C.), J. A. Fraser (North Riding C.C.), G. H. Gibson (Leicester C.C.), W. G. Harding (L. C. C.), P. Henderson, (Min. of Education), G. Hamilton Hogben (Tottenham and Hornsey M.B.S.), E. D. Irvine (Exeter C.B.), E. M. Jenkins (Manchester C.B.), J. D. Kershaw (Colchester C.B.), A. R. C. Margetts (Notts. C.C.), J. N. Matthews (Lancs. C.C.), J. B. S. Morgan (Derby C.C.), A. Morrison (Derby C.B.), G. S. Robertson (Liverpool C.B.), A. L. Smallwood (Bristol C.B.), J.W. Starkey (Surrey C.C.), Marion C. Taylor (Sheffield C.B.), Vera C. Veitch (Stoke-on-Trent C.B.), Gladys C. Wilkinson (Cheshire C.C.),

B.C.G. Vaccination

Dr. T. M. Pollock, M.D., CH.B., Physician in Charge, Tuberculosis Vaccines Clinical Trial, Medical Research Council, then gave a most instructive talk on B.C.G. Vaccination, illustrated by lantern slides. The varied questions and comments showed the great interest which the paper provoked.

BOOK REVIEW

The Eczemas. A Symposium by 10 Authors. Editor : L. J. A. Loewenthal, Edinburgh ; E. & S. Livingstone, 1954. (Pp.267. Price 35s.)

Dr. Loewenthal has collected a strong international team to help him clarify the problem of eczema. Although intended for general practitioners and specialists in other branches of medicine than dermatology, it contains chapters by Haxthausen, Storck and Burckhardt which summarise brilliantly the up-to-date experimental work on eczema. Any dermatologist will find much food for thought in these chapters alone,though they presuppose in the reader a fairly advanced knowledge of dermatology.

The clinical aspects of eczema are dealt with very adequately by Bettley (Contact Eczema) : Sulzberger and Witten Atopic) Eczema) : Peterkin (Seborrhoeic Dermatitis) : and Gordon (Eczematous eruptions with special features).

In his attempt to produce a guide to the eczemas, the Editor has in places, made it sound perhaps too easy. In his analysis of the origin of his own cases of extensive eczema, he has allotted a specific cause to a very high proportion and he plausibly explains that the remainder may not have given an adequate history. Whilst the diagnosis of endogenous eczema is undoubtedly a confession of failure, cases do exist where no explanation of an exogenous cause can be found.

It is a truism of dermatological therapy that as far as the dermatologist is concerned, one man's meat is another man's poison, but in a book designed to simplify the existing problems, a formulary which contains 35 prescriptions could perhaps be pruned.

The Editor in his preface seeks to ward off the criticism that there is no chapter on psychosomatic influences, but though there is no scientific proof that emotional disorders play an etiological part in eczema, the treatment of eczema can be improved by an awareness of the existence of the psyche.

Whether one agrees with him or not, Dr. Loewenthal has the courage of his convictions and this book will certainly stimulate discussion.

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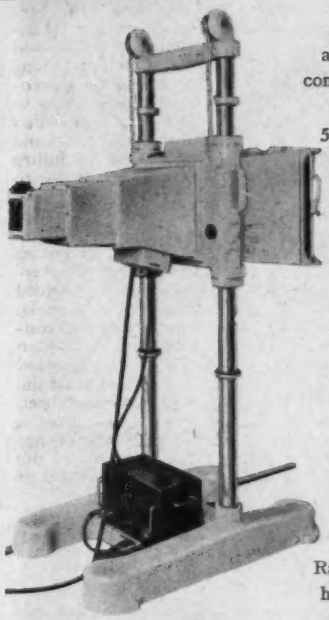

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